THE JOURNAL OF THE

FLORIDA MEDICAL

ASSOCIATION, INC. July 1985 Vol. 72, No. 7

SPECIAL ISSUE ON CHILD ABUSE

UP-TO-DATE!

FPIR Systems mean Quality Service.

The new management of Florida Physicians Insurance Reciprocal stresses quality control of the Underwriting , Accounting and Claims Processing functions. The new management team is experienced in operating medical professional liability insurance companies and understands the unique needs of the physician-owned company. FPIR is the only company sponsored by the Florida Medical Association and it stands ready to offer its experienced team for Florida's physicians.

For more information, please contact:

FLORIDA PHYSICIANS
INSURANCE RECIPROCAL

1000 Riverside Av / P.O. Box 44033 / Jacksonville,Fl 32231-4033
Telephone (904) 354-5910 WATS: 1-800-342-8349

FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

July 1985 "Doctors Helping Doctors" Vol. 2 — No. 3

Georgia IP Program Publishes Data on First Decade Experience

Family physicians and general practitioners comprise the largest single group entering treatment in the first decade of the Medical Association of Georgia's Impaired Physicians Program.

FPs and GPs accounted for 193 or 28.6 per cent of the 675 admissions from the beginning of the program in 1974 to the end of July 1984. This is more than double their representation in the total physician population (12.5 per cent), according to Karl V. Gallegos, M.D., and Merrill Norton, R.Ph., in an article published in the November 1984 issue of *Journal of the Medical Association of Georgia.*

Internists had 85 admissions or 12.6 per cent of the total, but this is somewhat below their proportion of the total physician population (15.5 per cent). Anesthesiologists made up 10.4 per cent of the patient load but account for only 3.5 per cent of the total population.

"There appear to be 'vulnerable' specialties that may have an increased risk for chemical dependence: anesthesia, family or general practice, and emergency medicine," the authors wrote. "Drug availability, job stress, and boredom are believed by the authors to be aspects of these specialties that make individuals within their ranks at risk for chemical dependence."

The article listed the 10 specialties most commonly seen in the Georgia program and compared their percentage part of the total patient load with their percentage of the total physician population as determined by the American Medical Association:

	IPP Population		AMA Population
	Frequency	Pct.	Per Cent
Family Practice or General Practice	193	28.6	12.5
Internal Medicine	85	12.6	15.5
Anesthesia	70	10.4	3.5
General Surgery	45	6.7	7.1
Psychiatry	42	6.2	5.8
Ob-Gyn	39	5.8	5.6
Emergency	24	3.6	1.6
Pediatrics	22	3.3	6.1
Orthopedics	21	3.1	3.0
Radiology	19	2.8	2.0
Other	115	17.0	37.3

By sex, the patient population broke down to 650 male and 25 females. Women physicians entering the Georgia program comprised a much smaller percentage than their representation in the total physician population (3.7 per cent vs. 12.2 per cent).

Veterinarians Donate $6,000 to IP Program

The Florida Veterinary Medical Association (FVMA) has made a donation of $6,000 to the FMA-FMF Impaired Physicians Program.

William F. Casler, D.V.M., J.D., of St. Petersburg Beach, presented the check to IPP Medical Director Roger A. Goetz, M.D., during an Intervention Workshop in Jacksonville on May 26.

Dr. Goetz and his wife, Kay, presented the program for the half-day session, which was attended by about 30 veterinarians.

The FVMA has been the health professional organization most supportive of the IPP through its Executive Vice President, H. Larry Gore, D.V.M., and others. Several impaired veterinarians have been treated and rehabilitated through the IPP.

All States Now Have Impairment Programs

All state medical associations now have some sort of a program to deal with the problem of the impaired physician.

AMA's Board of Trustees reported to the AMA House of Delegates in Chicago last month that the programs differ greatly from state to state. Some programs are low-key, keep no records and provide help only if the physician wants it.

Other programs have a more assertive approach. They investigate and advise the physician he needs treatment. If he does not agree to enter treatment and remain in therapy until discharged, the impaired physician risks having his case reported to the licensing board.

Most state association programs fall somewhere between these two extremes, the AMA report said.

The Florida IPP offers more complete efforts to assist the sick physician before his addiction begins to cause great troubles in the lives of others as well as his own. By agreeing to treatment within the IPP, the troubled physician gains an advocate before the Florida Board of Medical Examiners.

Want to Help a Troubled Friend? Help Is Just a Phone Call Away

(Editor's Note: Following is the first of a series of brief articles describing various facets of the Impaired Physicians Program prepared by Medical Director Roger A. Goetz, M.D.)

A telephone call to the Florida Medical Foundation's Impaired Physicians Program is all that is needed to begin a process designed to help the afflicted physician, his professional associates, his hospital, the medical consumer and the physician's family.

Early notification is important. All too often calls are received too late, after many difficulties have occurred and when the medical associates of the impaired physician are already in some form of jeopardy.

The call is received by the confidential staff of the IPP. This staff is separate from that of the Florida Medical Association/Foundation. It has a separate office and telephone system. The caller need not identify himself to report an impaired physician or to receive information and guidance. The program protects both the caller and the troubled physician.

The call is transferred to the author as Medical Director of the IPP or, in his absence, to the physician on call for further information.

A case file is begun and the situation is evaluated with the assistance of local individuals experienced in impairment and other confidential sources, retaining the troubled physician's anonymity.

After adequate information is obtained and verified, action is taken. This usually consists of counselling and exchange of information with medical associates to help them and the troubled physician. An intervention may then be necessary, and treatment arranged.

NEW IP NUMBER

Physicians wishing to refer colleagues to the FMA-FMF Impaired Physicians Program should call:

(904) 354-3397

Drug Education Course Planned

A work group consisting of representatives of the FMA Council on Scientific Activities and Committee on Substance Abuse has begun designing a CME curriculum to help physicians sharpen up their drug prescribing habits.

They hope to offer the program for the first time in the spring of 1986. Topics will include non-chemical approaches to pain and stress management, the disease concept of addiction, and the problem of the patient who is taking multiple drugs ordered by two or more prescribers.

"Caduceus" Prints Still Available

Looking for a worthy cause to help?

Then consider a donation to the Florida Medical Foundation's Impaired Physicians Treatment Loan Fund. Donations are tax deductible.

In return for a gift of $300 or more, the Foundation will give the donor an authenticated and numbered reproduction of "CADUCEUS", the well-known painting by the late Jacksonville artist Lee Adams.

Adams created "CADUCEUS" especially for the old FMA Headquarters Building in Jacksonville almost 30 years ago. The original still hangs in FMA's present office.

Prints are shipped unframed in a protective mailing tube. They make excellent gifts for close relatives and friends on special occasions such as medical school or college graduation, anniversaries and birthdays.

Checks made payable to "Florida Medical Foundation" and designated for the "Impaired Physician Loan Fund" should be mailed to the Foundation, Attn: Mr. Edward D. Hagan, P.O. Box 2411, Jacksonville, FL 32203.

Dr. Selander Renamed To Committee Chair

FMA President Luis Perez, M.D., has appointed Jacksonville family physician Guy T. Selander, M.D., to his sixth consecutive term as Chairman of the Committee on Impaired Physicians.

Other members of the Committee for 1985-86, all reappointed, include: Arvey I. Rogers, M.D., Miami; John F. Mason, Jr., M.D., Panama City; John M. Butcher, M.D., Sarasota; Mrs. B. David (Edie) Epstein, Key Biscayne; Hector Mendez, M.D., Orlando; Nelita R. Ano, M.D., South Daytona; Harold L. Ishler, Jr., M.D., Clearwater; Laurin G. Smith, M.D., Vero Beach; and Dolores A. Morgan, M.D., Miami Beach.

The Fifth Annual Section on Chemical Dependency at the FMA Annual Meeting in May featured a panel discussion on "Medico-legal Implications of Physician Substance Abuse," which was moderated by E. Joan Barice, M.D., of Palm Beach Gardens (standing). Panelists included (left to right): Roger A. Goetz, M.D., IPP Medical Director; Dolores A. Morgan, M.D., Miami Beach; and Richard J. Feinstein, M.D., Miami, a member of the Florida Board of Medical Examiners.

BALANCED CALCIUM CHANNEL BLOCKADE!

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

Only Ativan® (lorazepam)

offers all these benefits in addition to rapid relief of anxiety:

relief of anxiety associated with depressive symptoms

clearance not significantly delayed by age, liver or kidney dysfunction

cumulative sedative effects seldom a problem

little likelihood of drug interaction
(all benzodiazepines produce additive effects when taken with alcohol or other CNS depressants)

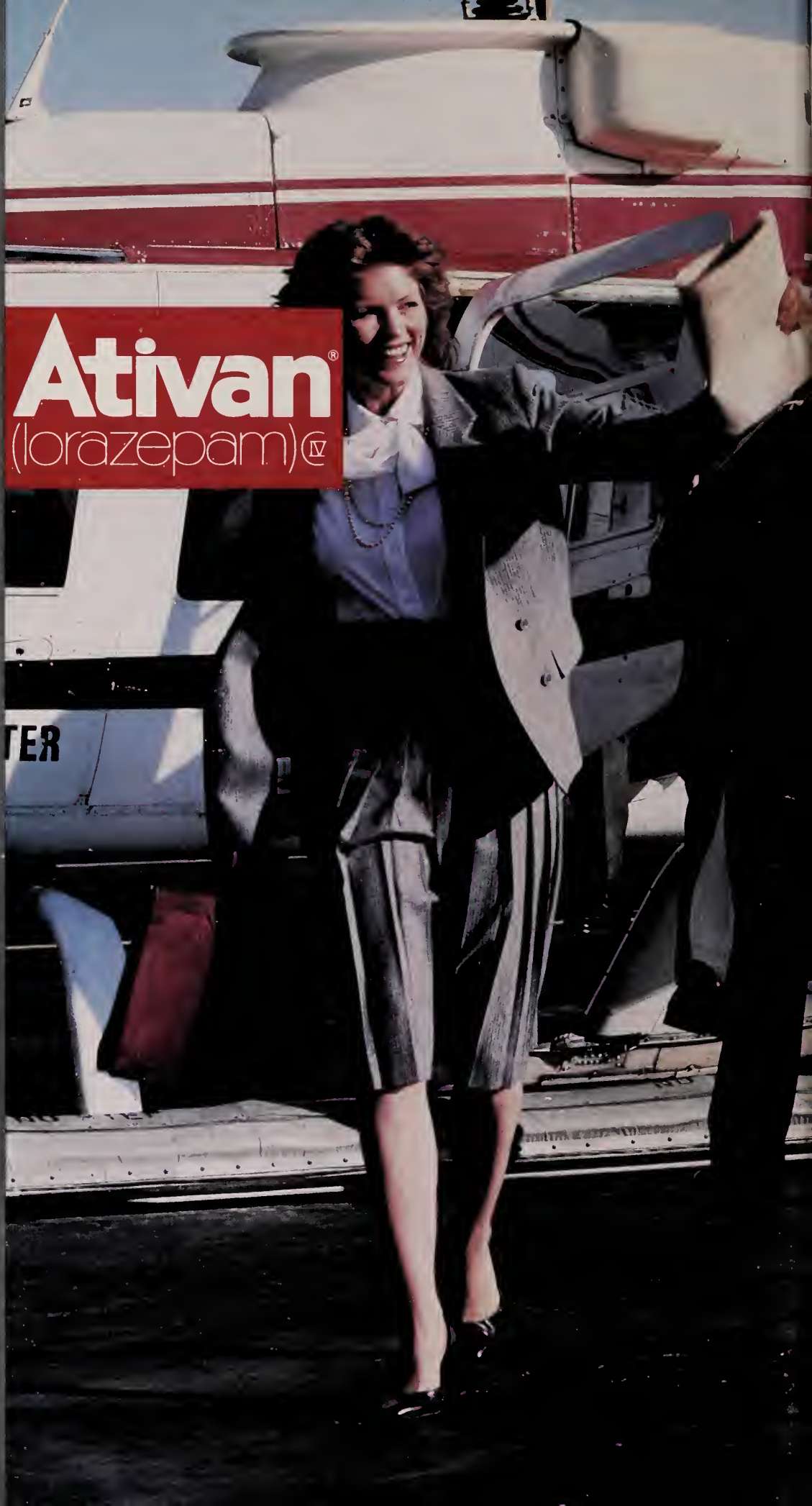
no significant changes in vital signs in cardiovascular patients*

short duration of action, simple metabolism

*Benzodiazepines have not been shown to be of benefit in treating the cardiovascular component.

See important information on preceding page

Wyeth Laboratories
Philadelphia, PA 19101



No One Is More Ill Than A Patient Who Tries To Hide His Illness From His Doctor.

You know it's not your everyday patient problem. Alcoholism is far different from most other diseases. Patients try to hide it from you. They resist treatment. They deny they have the disease at all.

Such a complex physical and emotional problem usually requires extensive evaluation. And intervention counseling is frequently needed.

If you are a specialist in addiction treatment, you're equipped to deal with these problems. If not, consider Brookwood Recovery Center as your specialist and partner in the treatment of alcoholism and drug abuse. We're a specialized facility staffed to serve both your patient and patient's family. Our nationally recognized treatment programs have given us one of the best recovery rates in the country. And once recovered, your patients and their families return to being the kind of patients that let you help them once again.

For further information on how a Brookwood Recovery Center can help you effectively treat this problem, call our treatment center in Orlando (305/841-7071) or Tampa (813/884-1904 or, toll-free in Pinellas County, 813/447-4806) anytime, day or night.

BROOKWOOD RECOVERY CENTERS
A health care service of American Medical International

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC

JULY 1985 Vol. 72, No. 7

CONTENTS

SCIENTIFIC ARTICLES

SPECIAL ARTICLES

EDITORIALS

COVER

This months cover of *The Journal* depicts the theme of this Special Issue on Child Abuse. The photograph was reprinted with permission from The Childrens's Medical Services.

Subscription Rate: $15.00 per year, single copy $1.50 (special issues $2.50) plus 5% sales tax within the State of Florida. Address: *The Journal of the Florida Medical Association, Inc.*, [ISSN 0015-4148], 760 Riverside Avenue, Jacksonville, Florida 32204. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida. **POSTMASTER: Send address changes to Post Office Box 2411, Jacksonville, FL 32203.**

DEPARTMENTS

The AMA puts current information at your fingertips

The first nationwide medical information network brings a new dimension to the way in which physicians can keep abreast of the latest knowledge in their profession. Through the use of a low-cost computer terminal you can have access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips . . .

DATA BASES:

Drug Information

- Contains up-to-date information on the clinical use of drugs
- More than 1,200 individual drug preparations marketed over some 5,000 trade names
- Can identify drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions

Excerpta Medica Physicians Information Retrieval and Educational Service

- Index to clinical literature — aids subscribers in locating recent articles and peer reviewed papers that have appeared in more than 300 medical journals worldwide
- Periodicals selected for inclusion in this service cover over 78 specialties and subspecialties
- Helps physicians locate relevant articles quickly and to stay abreast of new developments — saves time

Continuing Medical Education

- Developed by Massachusetts General Hospital in conjunction with the Harvard Medical School
- Allows physicians to earn Category I ACCME credits
- Provides individualized self-paced learning experiences based upon computer simulated patient cases
- Physicians will interact with teaching situation through four predetermined styles: multiple choice, vocabulary, fee text, and tutorial
- Provides confidential means of self-assessment for practicing physicians
- Solutions to problems presented in each teaching scenario can be reviewed and evaluated instantly

Socio-Economic Bibliographic Information

- Guide for locating current articles on the nonclinical aspect of health care
- Includes 4,200 citations from more than 700 health care publications
- Subject areas include economics, education, ethics, international relations, legislation, medical practice, political science, psychology, public health, sociology and statistics
- Convenient ordering of full text reprint of articles directly from the AMA through MED/MAIL

Medical Procedural Coding and Nomenclature

- Provides uniform coding and nomenclature system for reporting medical services and procedures performed by physicians
- Contains 6,000 descriptions of procedures

Disease Information

- Contains descriptions of diseases, disorders and conditions

GTE Telenet
Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION,
PLEASE CONTACT THE
FLORIDA MEDICAL ASSOCIATION, INC.
JACKSONVILLE, FLORIDA
TELEPHONE 904/356-1571

Board of Governors: an open forum

The Board of Governors Meeting of the Florida Medical Association, Inc., June 28-29, was a fine example of unity in action.

The usual meeting between the Executive Committee and the Chairmen of the various councils and committees, as well as the Board itself, was enhanced by the attendance of several county society medical presidents and executives. The dynamic participation of all the members present was vibrant and enlightening. All were heard on every issue they wanted to address, and the positive and well thought out decisions of the Board were attuned to the opinions expressed by all.

It was an excellent example of an open forum of a democratic environment at work for the common good of the Association as a whole, and for the people of Florida whose health and well-being are our primary responsibilities.

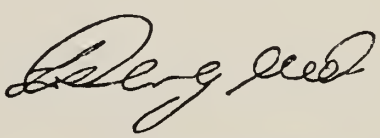
Short and long-term programs geared to present and future issues ranging from public relations to the political forum were decided in general terms as the goals of our Association.

The decisions made at this meeting will be published in a future edition of *The Journal*. I plead with you to carefully and thoughtfully consider every issue so the proper implications of each one are understood. Your comments and positive suggestions are welcome on each one of our programs. I emphasize that these programs deal with our problems. You must all agree that we have leaders in our midst whose clear thinking is based on moral and ethical principles, and who express their thoughts in an intelligent and logical manner.

Members of your Board of Governors with years of experience in different fields and endeavors have the common goals and principles of medicine which we all understand. The Board of Governors made the final decision on all the issues in a very positive manner, giving birth to a specific direction for the Association's future, a direction in which we want to function in order to confront the problems that the State and Federal Government present to us face to face. We must find areas of understanding, as well as areas of discrepancy, and work on them united as one body. We derive strength from each other within our family of medicine and only we are the experts in this field.

Through his life, the practicing physician sees patients everyday and realizes the shortcomings of government sponsored health programs based on economics rather than quality of care. The Florida Medical Association and the American Medical Association on the national level are also aware of such problems and together, along with the county medical societies, form the strongest federation to fight the government interference that fails to take into consideration the health and well-being of our population. Our individual physicians and medical societies are the full guardians of the health of the nation.

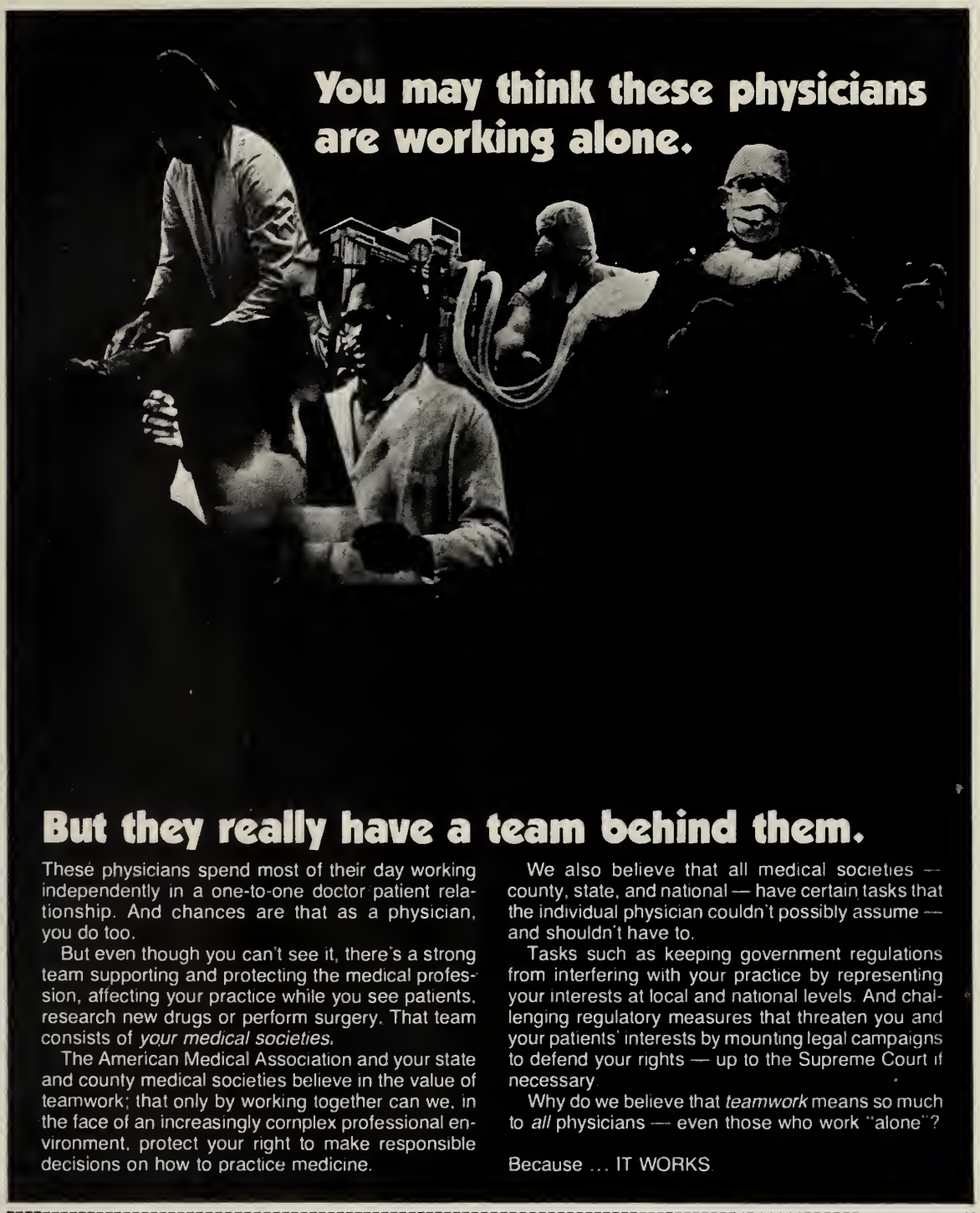
As physicians, we must unite. We must encourage our individual members at the local medical society level to participate in the deliberations and give us their input. We must strengthen our channels of communication so that each concerned member communicates with the Board of Governors, county society presidents, and representatives. With participation by individual members and strengthened communications, we can work together to attain our goals and accomplish what has never been accomplished before. Different factions may choose to reject this new united direction and concentrate on isolated issues. They are blind to the overall picture in the state and will produce no positive results. Our strength is our unity.



A Kiss Can Save A Life

When you kiss your child, you give and receive love. But your kiss could also be a test for cystic fibrosis, an inherited respiratory and digestive disease. An excessively salty taste to the skin is one symptom of cystic fibrosis. Call your doctor or local Cystic Fibrosis Foundation Chapter for more information. Early diagnosis and treatment can be the key to a better quality of life for CF children.

Meantime, kiss your baby. It's a good idea, anyway.



But they really have a team behind them.

These physicians spend most of their day working independently in a one-to-one doctor patient relationship. And chances are that as a physician, you do too.

But even though you can't see it, there's a strong team supporting and protecting the medical profession, affecting your practice while you see patients, research new drugs or perform surgery. That team consists of *your medical societies.*

The American Medical Association and your state and county medical societies believe in the value of teamwork; that only by working together can we, in the face of an increasingly cornplex professional environment, protect your right to make responsible decisions on how to practice medicine.

We also believe that all medical societies — county, state, and national — have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

Tasks such as keeping government regulations from interfering with your practice by representing your interests at local and national levels. And challenging regulatory measures that threaten you and your patients' interests by mounting legal campaigns to defend your rights — up to the Supreme Court if necessary.

Why do we believe that *teamwork* means so much to *all* physicians — even those who work "alone"?

Because ... IT WORKS.

Join Your Medical Societies Today.

For more information, contact your state or county medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

☐ Please send me information on AMA, county, and state society membership.

☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name _____

Street _____

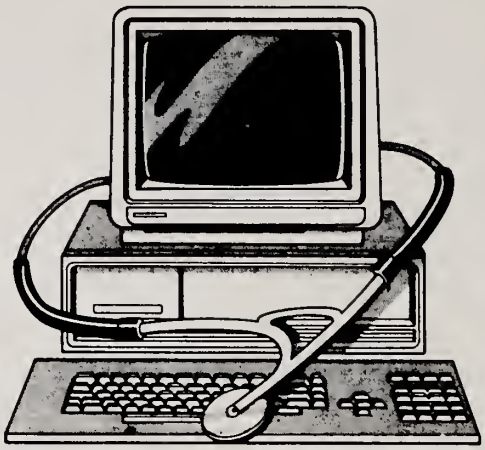
City _____ State _____ Zip _____

County _____

MANAGE YOUR OFFICE MORE EFFECTIVELY WITH THE MPM 1000 SYSTEM AVAILABLE THROUGH SOUTHERN MEDICAL ASSOCIATIONS PHYSICIANS' PURCHASING PROGRAM

Manage your office more effectively with the MPM 1000 System available through the Physicians' Purchasing Program.

Managing your office shouldn't be hard; however, with the current insurance requirements and



the impending Medicare changes looming on the horizon, it will get more difficult. You should call Curtis 1000 Information Systems or Southern Medical Association to find out how the MPM 1000 can help make your practice run more effectively.

AVAILABLE ON IBM A/T

MPM 1000 Simplifies Your Paperwork
You will be able to reduce the mountains of paperwork by using your MPM 1000 system to process all your insurance, complete your billing plus instantaneously sort and file necessary information.

MPM 1000 Speeds Up Your Cash Flow
The MPM 1000 system will increase your daily bank deposits by processing all your insurance and patients' receivables quickly.

MPM 1000 Improves Your Practice Management
With the MPM 1000 system you can easily and intelligently manage your practice with computer generated reports. Trends and problems are easily identified so you can take corrective action before they become serious.

MPM 1000 Is A One Source Solution
The MPM 1000 is a one source solution. With your system you receive all hardware (IBM or Texas Instruments), software, complete five day training program and responsive after sale support.

IBM PC/AT At Discount
Best of all, these systems are available through SMA Services, Inc., Physicians' Purchasing Program with substantial discounts on IBM and Texas Instrument equipment.

FOR MORE INFORMATION, please fill out the coupon below and mail it to Southern Medical Association, or for faster service call Southern Medical at (205) 945-1840 or Curtis 1000 Information Systems at 800-241-4780.

☐ **YES!** I would like more information on MPM 1000

My interests are: ☐ Immediate ☐ Long term ☐ Please contact me for a survey
I am a member of SMA ☐

Name (Please Print)

Address

City State Zip

Specialty ( ) Office Phone

Mail to: CURTIS 1000 INFORMATION SYSTEMS
2296 Henderson Mill Road
Suite 402
Atlanta, Georgia 30345

Medicine under the gun

The new climate where health care is being increasingly shaped by a welter of political and economic forces is eroding the traditional medical image and redefining the course of medicine. Medicine is now looked upon as just another type of business, while physicians are perceived as new entrepreneurs who are shedding their traditional white gowns for the gray flannel suits of Wall Street. This shift in focus is dramatically bringing about a wave of changes, some of them revolutionary, with no indication that they will grind to a halt soon. While the impact of these changes is still being debated, the consensus among physicians is that medicine had seen its better days.

The much-ballyhooed high cost of medical care has been the big stimulus behind all these changes. From a period not too long ago when there was a virtual bonanza for everybody, we have entered an era where the pie is getting smaller and smaller. The picture becomes even more muddled with an expected overabundance of physicians competing for a shrinking market. Only five years ago, nobody could have imagined that these numbing developments would ever come to pass. Medicine, after all, has never been perceived as a business, and traditionally has been immune from the pernicious influence of political and economic forces.

The increasing dominance of political and economic imperatives in medical care places the medical profession and physicians under a glaring spotlight. Although the escalation of medical costs the past several years can be attributed to a number of reasons — inflation, medical technology, an aging population, and rising demands for medical care, among other things — physicians are visible targets and convenient scapegoats in the whole scheme of things. Medicine may have brought forth miracle drugs and exciting technological advances; at the same time, almost everybody knows that physicians have benefited handsomely from the situation. The six-figure income of most physicians is common public knowledge. So is their image of affluence. Is it any wonder then that the government has found it easy to sidestep them by onerously imposing a new order of things? Physicians are certainly not getting much sympathy from the public, which perceives the problem as just another pocketbook issue for doctors. Beset by mounting government regulations on one hand, and pushed on the other by a sagging public image, physicians have found themselves as sacrificial lambs on the altar of cost containment.

It is a deep predicament for physicians to be in. To believe, however, that physicians have put themselves into a deep hole and have nobody but themselves to blame, as a lot of people think, is to miss the point. Most physicians are honest, hard-working, and motivated by a genuine desire to help their patients. There are physicians who obviously practice their profession for monetary motives and who have made a bundle by their profiteering, but they constitute a tiny minority. The perceived excesses of the medical system cannot by any stretch of imagination be laid on the doors of physicians. The advent of better patient care and modern scientific advances made medical care more expensive, but that should have been expected. Americans are now living longer and healthier lives, a number of diseases have been eradicated, and many disabling ailments can now be kept under control. Medical progress, however, has become a cruel paradox, and physicians are paying dearly for it.

The current situation where physicians find themselves being dislocated from their traditional roles as decision-makers in medicine by the govern-

ment, corporations, insurance companies, and other third parties will have deep repercussions on the future of medicine. In addition, the political and economic forces now at play may lead to the dismantling of what is indisputably the best system of medical care ever devised anywhere, with the increasing specter that socialized medicine may not be far behind.

Most physicians entered the profession of medicine imbued with humanitarian motives, but a big number of them are getting cynical about what is going on. How can physicians maintain the revered ideals of their profession and instill them to younger generations when dollars and cents are becoming the central focus of the physician-patient relationship? The current public perception of the medical profession confirms the shifting moods of Americans about their doctors. In a recent research conducted for the AMA, 54% of respondents felt that doctors do not care as much about people as they used to; 44% believed that doctors are in medicine only for the money and prestige; and 61% thought that doctors do not spend enough time with their patients. We can console ourselves by thinking that patients still love us, but I think they are sending us an urgent message.

The increasing economic pinch engendered by the new environment is forcing physicians to scramble for the shrinking base of patients. Physicians are advertising more, attending more market seminars, joining or forming their PPOs, IPAs, and PPOs, opening walk-in clinics, consorting with hospitals and insurance companies, and exploring every opportunity to preserve their share of patients. Never before has the medical community been in such ferment over the brewing economic storms.

Amidst all these developments, physicians are worried about what will happen to the quality of medical care. It is a legitimate fear. Sporadic reports of shortcuts in patient care, premature discharges of patients, and rationing of medical care are an ill omen of what may be coming. Studies are in progress to make sure that such things do not happen routinely; in the meantime, physicians are hoping that the new system is not going to breed all the evils that other countries like Great Britain and Canada have experienced. The ghost of history will haunt those who have not learned its lessons.

It is an interesting period in the history of medicine; at the same time, it is fraught with portents that happy days may not be here again.

R. G. Lacsamana, M.D.
Editor

Malpractice relief: is it coming?

In a representative democracy, elected officials must try to solve constituent and societal problems as efficiently and economically as possible, because individuals and groups can no longer solve many problems themselves. Laws are enacted in response to such requests for assistance.

For over ten years, the Florida legislature ignored rising costs of professional liability insurance and health care, and pleas from physicians and hospitals to investigate and ameliorate the on-going malpractice crisis. Elected leaders chose to interpret supplications from physicians as just one more aspect of the battle between physicians and lawyers in their mutual quest for power and cash.

There are some individuals, including a few well known and vocal plaintiff attorneys from South Florida, who vehemently deny that a malpractice crisis really exists, and if they are correct then there is no reason to institute major legislative changes. But why are so many insurance and reinsurance companies either going bankrupt or ceasing to write professional liability coverage for physicians in Florida, and why are neurosurgeons, anesthesiologists and obstetricians being asked to pay 70 to 90 thousand dollars a year for coverage, and why are physicians assigned to the JUA high risk pool in those same high risk specialties being asked to pay an annual premium of two hundred thousand dollars or more?

A CBS television news report on malpractice discussed the possibility that the crisis is being created by insurance companies, which, it was alleged, are accumulating billions of dollars in profits while insisting on higher premiums each year. If this is true, then it is the job of state government or Congress to investigate insurance companies to find out the validity of these allegations. A neurosurgeon in Tampa or an obstetrician in Miami, struggling with an annual premium of ninety thousand dollars, and a busy operating and office schedule, has neither the time, expertise, nor authority to question the insurance industry about its policies.

Physicians in Florida, led by the Florida Medical Association, have worked hard for ten years to obtain legislative relief and were able to have several important pieces of legislation enacted, including the creation of medical mediation panels which functioned efficiently until they were declared unconstitutional by the Florida Supreme Court. The panels were a creative and equitable way to filter out unworthy suits and increase the chance for an out-of-court settlement. Almost identical mediation panels still function in other states where they have not been challenged by the judiciary.

The creation of the Florida Patient's Compensation Fund by the Legislature, although perhaps conceived with good intentions, was enacted to provide umbrella coverage for physicians and hospitals in the midst of rising premiums and million dollar awards, without really addressing the basic defects in the tort system. By neglecting to set limits on liability, however, the Legislature exposed the PCF and all their clients to bankruptcy and ultimate failure which did occur, and physicians and hospitals are still paying assessments for years during the late 1970s and early 1980s when the PCF was providing umbrella coverage in the face of multi-million dollar jury awards. When it went out of existance, the PCF left small insurance companies and self insurance trusts with unlimited assessability, a devastating situation that ended when large reinsurance companies, like Northstar and Lloyds of London, decided to participate to fill the void, but at great increase in cost of protection.

After the 1983 legislative session, with no help in sight for any significant relief, the Florida Medical Association decided to by-pass the Legislature by going directly to the electorate with a referendum for constitutional reform. Over 700,000 signatures were obtained to place the referendum on the ballot, but because of possible legal errors in their preparation, the Florida Supreme Court removed it from the ballot several weeks prior to the November 1984 election.

The degree of concern expressed by nearly three quarters of a million citizens of this state as signatories of that referendum, and the almost total unwillingness of elected representatives to address the matter in a constructive way, prompted the South Florida Health Action Coalition to empanel a group of prominent Floridians to hold hearings around the state from October 1984 through February 1985, culminating in recommendations to the Legislature at the beginning of the 1985 session. The panel obtained its financing, authority, and prestige from its members: executives and officers from a large number of private and public companies and municipalities from around the state, who were very much aware that the malpractice crisis was severely increasing the cost of conducting business in Florida.

Governor Graham responded to the increased public interest created by the FMA referendum and appointed his own panel of experts to hold hearings and make recommendations to the Legislature. The creation of a second panel, however, was expensive and duplicative and it would have been less expensive and more productive had legislative leaders themselves established a fact-finding commission to hold hearings and make recommendations to the full Legislature.

The 1985 legislative session started with a flurry of activity when House Speaker James Harold Thompson openly expressed interest in passing malpractice legislation. He asked Rep. Tom Gustafson (D-Broward), Chairman of the House Health Committee, and Rep. Art Simon (D-Dade), Chairman of the Subcommittee on Medical Malpractice, to prepare a house bill with enough innovative changes to ameliorate the crisis, yet appease all protagonists in the face of the predicted lobbying efforts by physicians, trial attorneys, and consumers, including the so-called victims of malpractice who traveled to Tallahassee at the clandestine expense of the plaintiff bar to publicly deride and embarrass the medical doctors of this state.

The subcommittee, which labored tirelessly for almost the entire legislative session, produced a 115-page house malpractice bill, which was presented to the Senate in the closing days of the session. While the house bill was not, and could never be exactly what physicians believed is necessary to correct the malpractice crisis completely, it dealt fairly with many areas of physicians' concern.

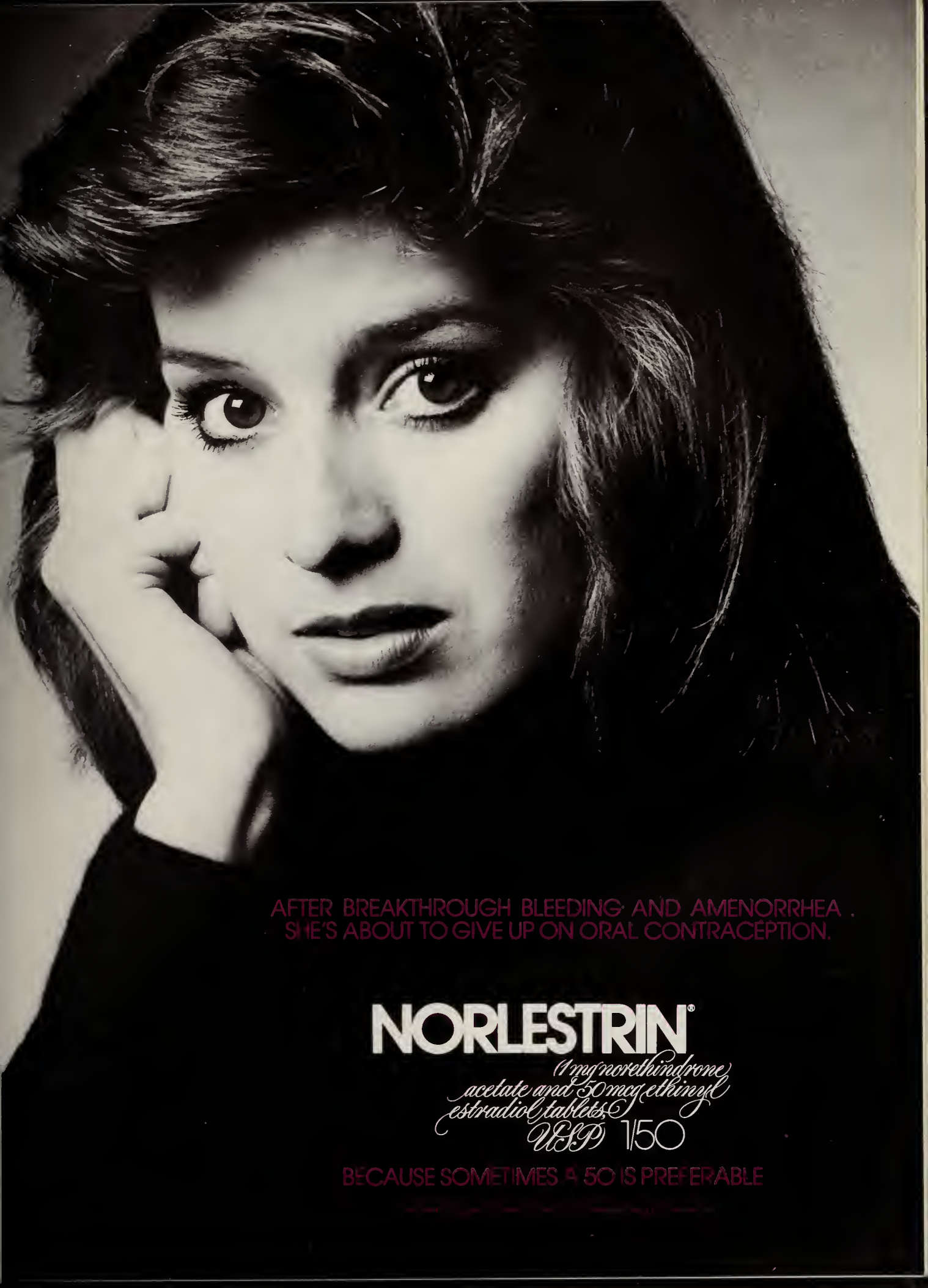
It is interesting to note that in prior years it was the Senate which wrote malpractice legislation and the House which traditionally presented stumbling blocks, but during the final days of the 1985 session, the Senate seemed intent on destroying the entire 115 page house bill without offering any compromise or legislation of its own. On Thursday, May 30, the Miami Herald reported that the malpractice bill was dead because the Legislature was intent on adjourning one day early, on Thursday night, reportedly to save taxpayers' money. In the last hours of the session, reportedly in return for ending opposition to the Mayo Clinic bill, Senate leaders promised physicians the passage of malpractice legislation, and the result is HB 1352.

To summarize some important parts of HB 1352: 1) setting of community standards for expert witnesses; 2) sliding scale for attorneys' fees; 3) structured settlements which are mandatory for future damages of over a half million dollars; 4) 90 day cooling-off period, coupled with arbitration; 5) increased immunity for hospital boards and peer review committees; 6) increase in Board of Medical Examiners by one member to 12; 7) loss or settlement of three or more suits within five years of $10,000 or more is now a ground for discipline by the Board or Medical Examiners; 8) contributory fault which does not eliminate joint and several liability but makes each defendant responsible for only proportionate share of damages for any defendants from whom the judgement cannot be collected; 9) requirement of hospitals to have risk managers and competent medical staffs, and imposition of liability on hospitals for failing to use due care in these obligations; a hospital may purchase a comprehensive umbrella PLI policy for itself and its staff, with optional staff participation; 10) grounds for license restriction for physicians who order diagnostic tests that are not reasonably calculated to assist the health care provider in caring for the patient; 11) mandatory PLI of $250,000/$750,000 for physicians with hospital staff privileges and $100,000/$300,000 for those who do not belong to any hospital staff. This becomes effective on January 1, 1987; 12) 60 hours Category I CME every three years, as condition of medical licensure; 13) a valid medical license to obtain professional occupational license in any city or county in Florida.

There are many parts of HB 1352 which I have not addressed here at all, including some that may be important to individual physicians around the state, and I urge every physician to obtain a copy of this law and read it thoroughly. Dr. Luis Perez's President's Memo of June 11, 1985, mailed to all FMA members, discusses HB 1352, and includes a detailed evaluation of the entire law, as well as per-

tinent comments by Dr. Perez. He believes that physicians have gained a great deal through this legislation, and although the Legislature failed to place a cap on general damages or eradicate joint and several liability, it does represent the beginning of a solution to a malpractice crisis that has persisted unabated for over ten years. I join Dr. Perez in thanking Reps. Simon and Gustafson, Senator Mattox Hair (D-Duval), House Speaker James Harold Thompson and Senate President Harry Johnston for all that they have done in initiating this solution to a nightmare for physicians that began over a decade ago. We should begin making plans now for the 1986 legislative session when we can request legislative refinement and additional changes in the malpractice laws that govern this state.

Richard J. Feinstein, M.D.
Miami
Contributing Editor


AFTER BREAKTHROUGH BLEEDING AND AMENORRHEA
SHE'S ABOUT TO GIVE UP ON ORAL CONTRACEPTION.
NORLESTRIN®
(1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP)
1/50
BECAUSE SOMETIMES A 50 IS PREFERABLE

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows.

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders.
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders.
3. Cerebral vascular or coronary artery disease.
4. Known or suspected carcinoma of the breast.
5. Known or suspected estrogen-dependent neoplasia.
6. Undiagnosed abnormal genital bleeding.
7. Known or suspected pregnancy. (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products.

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives, however the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision, onset of proptosis or diplopia, papilledema, or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives, however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy. Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.
2. Preexisting uterine leiomyomata may increase in size.
3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.
4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.
5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.
6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.
7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.
8. Serum folate levels may be depressed.
9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.
10. Certain endocrine and liver function tests and blood components may be affected. (a) Increased sulfobromophthalein retention; (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability; (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone; (d) Decreased pregnanediol excretion; (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; benign hepatomas; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis; neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms; breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma; breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature; intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin 21 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin 21 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin Fe 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin FE 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin 28 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

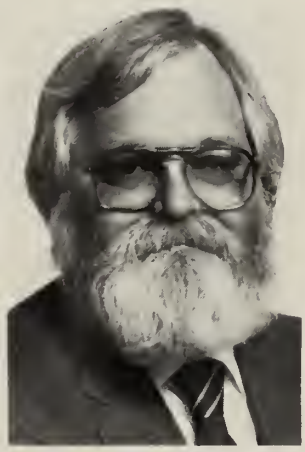
0901G131

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

PD-21-JA-2563-P-1(11-84)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
JULY 1985 Vol. 72, No. 7

Child abuse: old problem, new perspectives



There has been an exponential increase in reporting of child abuse and neglect in Florida over the past several years. This appears to reflect an increase in incidence and certain individual types of abuse have increased. Recognition and awareness, however, are key factors leading to the greater numbers of reported cases.

There is temptation to believe that child abuse is a problem of modern society but maltreatment has been practiced since the beginning of recorded history. Children were considered as chattel and, therefore, subject to the will or whim of parents. During several periods in history, infanticide was an accepted practice to deal with the overextended resources of society or similarly of an individual family. Nearly everyone is aware of child exploitation during the industrial revolution, the "spare the rod, spoil the child" philosophy of the Calvinists and Puritans, and the selling of children into a variety of types of bondage. Child abuse, therefore, is not a new phenomenon, but the recognition of children's rights has made a significant difference in the systems responsible for their welfare.

In 1874 the famous case of Mary Ellen in New York brought the issue of child abuse into focus. This child was being grossly maltreated by foster parents and there were no existing laws to protect her. Judicial relief sought under laws to prevent animal cruelty led to development of the Society for the Prevention of Cruelty to Children as an outgrowth of the Society for the Prevention of Cruelty to Animals. This development is the genesis of social work awareness of the problem of child abuse.

Medicine took longer to recognize the problem of abuse and neglect. In 1946 and 1955 reports appeared in the literature suggesting a connection between injuries and parental maltreatment. In 1962 when Henry Kempe coined the term "Battered Child Syndrome" medicine officially recognized the connection between child injuries and nonaccidental parental causation.

Child abuse is endemic and the only change recently has been a reluctant awareness of its presence. This fact coupled with a sense of children's rights has resulted in recognition of a need for action. It should be kept in mind, however, that we continue to provide mixed messages. Child abuse is only one form of of violence. We declare that violence against the child is wrong, but continue to maintain that violence is acceptable on television, in movies and even in schools. Role models are critically important in child development and mixed messages lead to developmental confusion.

Florida took an assertive position in protecting children by development of the statewide Child Abuse Reporting Hotline in 1971, development of Child Protection Teams in 1978, and allocation of Child Abuse Prevention funds in 1982. Many people in the state do not realize that our team system is unique. There are many child protection teams but none are linked into a statewide system directed by a pediatrician and utilizing the medical model for operation. The initial allocation of funds was to the Children's Medical Services program, Department of Health and Rehabilitative Services, and the entire system was designed and continues to operate under that program office. This administrative arrange-

ment—child protection teams as a medically directed service—is also unique in the country.

There has been upgrading of legislation for child protection every year by the legislature. The state is now seen as a leader in innovative programs for protection and abuse prevention. Concomitant with these improvements, there has been an expanding body of expertise in all areas. Many national and regional experts are recognized in this state and their work continues to be supported by Children's Medical Services. The products of some of these experts are included in this issue of *The Journal* and as we continue to expand our efforts in research more are expected to follow.

J.M. Whitworth, M.D.
Guest Editor
Associate Professor of Pediatrics
University of Florida
State Consultant
Child Abuse and Neglect
Children's Medical Services

Child abuse by burning

Alison H. Watkins, A.R.N.P.; Richard J. Gagan, Ph.D., and J. Michael Cupoli, M.D.

ABSTRACT: Surveys of child burn victims report that from 6% to 28% have known abusive etiology. Since causes are difficult to detect with many types of burns, these figures may underestimate the true incidence. Criteria are delineated for detecting abuse from various types of burns. Certain burns such as contact and immersion scalds may leave characteristic markings. By comparing the probable mechanism of the burning with the history of the developmental skills of the child, the physician usually can determine whether the burn was caused by abuse. Since the consequences of burn abuse to children are profound, including a death rate as high as 30-40%, the medical practitioner should be cognizant of the responsibility for careful examination and reporting. Children most at risk live in nonintact families that are mobile and have histories of employment difficulties and domestic violence. Children are especially vulnerable to hot water scalds and the public should be advised to limit hot water heaters to 120°. Citizens of sunbelt states should be educated concerning the potentially dangerous heat levels of automobile seats and restraining belts.

The Authors
ALISON H. WATKINS, A.R.N.P.
RICHARD J. GAGAN, Ph.D.
J. MICHAEL CUPOLI, M.D.
Ms. Watkins is presently employed as an instructor in Pediatric Nursing at the University of South Florida College of Nursing, and has experience in child abuse. Dr. Gagan is a sociologist and Associate Professor in Developmental and Behaviorial Pediatrics in the Department of Psychiatry, University of South Florida College of Medicine. Dr. Cupoli is Associate Professor of Pediatrics and Director of Child Development and Behavior, University of South Florida College of Medicine.

Burn injury is a traumatic event for a child and his family. The human suffering is immeasurable and treatment is often extremely costly and lengthy. Inflicted burns are an integral part of the battered child syndrome, yet experts believe numerous cases pass for accidents.[1-7] Increased awareness of abuse as a factor in burn etiology will decrease the risk of further injury to the child, decrease the potential risk of injury to his siblings and facilitate therapeutic intervention. When a burn of abusive etiology is unrecognized, the cost may well be a child's life.

Epidemiology • The true incidence of child abuse by burning is unknown. Epidemiological studies may present the likelihood of burn abuse through two types of conditional probabilities: proportion of burns among abused children (Table 1) and proportion of abused children among those presenting with burns (Table 2). Both types of surveys report an incidence of inflicted burns ranging from 6% to 28%. The varying statistics reported in the tables probably can be accounted for by differing thresholds of recognition. Obvious inflicted burns such as those caused by cigarettes, hot irons or radiators are rarely overlooked. Intentional scalding injuries, however, are similar in appearance to accidental burns and they may not be recognized as inflicted. Minor burns not requiring hospitalization but perhaps of abusive etiology are not included in these surveys. Thus, the stated incidence of burn abuse is likely to be an underestimation of its true occurrence. As many as 30% to 40% of burn-abused children die from their injuries, a mortality rate appreciably higher than when children are burned accidentally.[8,9] No explanation for this elevated rate is noted.

The most frequent cause of burn abuse is scalding with hot liquids. Of 25 cases Stone[2] identifies 15 (60%) scald burns, five (20%) hot metal contact

burns, and four (16%) flame burns. Hight[7] reports 87% of 142 burns as scalds and 13% as flame injuries. Sixty-seven percent of these nonaccidental burns occur in the kitchen or bathroom.

Chemical burns are not common manifestations of child abuse, although two cases have been reported.[1] We have seen a two-year-old girl with chemical burns to the vulva caused by lye. In the British literature, the history of a Cetrimide cleanser burn to an infant appears suspicious of abuse because of family history, but is not noted as such.[10] Burns from chemicals are often third degree because the tissue destroying capacity is present until the chemical is removed. There are no reports of child abuse by electrical burning in the literature. Several abusive instances of frostbite are reported. Although less frequent, frostbite injuries have the potential of being as severe as those caused by heat.[18]

Burn mechanism • The depth of a burn is a function of the temperature of the burning agent, exposure time, and thickness of the skin. Moritz and Henriques[19] note a reciprocal relationship between temperature of the agent and skin exposure time to the depth of the resulting burn. At a temperature of 49 C (120 F) liquid will not cause a full-thickness burn until the skin is exposed for ten minutes. Temperatures of 53 C (127 F) produce full-thickness burns with skin exposure of only two minutes. Young children's skin is appreciably thinner than that of adults. They sustain more severe burn damage with shorter exposure time and lower temperatures. At temperatures greater than 130 F, children can burn in about one-fourth the time of adults.[20] Handicapped persons with paralysis or sensory loss are also extremely vulnerable to burns because of their anesthesia, thin skin, and lack of mobility. The mean hot water

Table 1. — Child Abuse Surveys Including Inflicted Burns.

Source	Year	Span of Years	Number Abused Children	Number (%) Burn Abused Children
Lauer[11]	1974	1965-1971	130	16 (12)*
Stone[2]	1970	1965-1969	245	26 (11)
Lenoski and Hunter[12]	1977	1966-1977	712	43 (6)
O'Neill[13]	1973	1968-1973	110	31 (28)
Smith and Hanson[3]	1974	1971-1973	134	23 (17)
Hight[7]	1979	1971-1977	1518	142 (9)
Springthorpe[14]	1977	1973-1975	30	6 (20)

*Not including minor burns.

Table 2. — Burn Surveys Including Inflicted Burns.

Source	Year	Span of Years	Number Burned Children	Number (%) Burn Abused Children
Feldman[15]	1978	1963-1976	56*	16 (28)*
Hight[7]	1979	1972-1977	872	142 (16)
Ayoub and Pfeifer[16]	1979	1974-1976	26	5 (19)
Bakalar[8]	1981	1978	177	25 (14)
Fowler[6]	1978	1977-1978	300	17 (6)
Glasheen[19]	1983		396	34 (8)

*Tap water scalds only.

temperature in a survey of households in Seattle was 61 C (142 F). At this temperature, a ten second exposure to tap water results in a third degree burn to adults.[15] In Seattle, Feldman and his colleagues instigated a major public awareness program to reduce hot water heater thermostat settings. A similar prevention effort in Tampa has met with only limited success.

Detection • Abusive contact burns are generally recognizable but differentiation between accidental and inflicted scald injuries may be difficult. Although specific burn patterns of inflicted injury may not exist in all cases of abuse, Lenoski and Hunter[12] identify four specific patterns which, if present, can assist the professional in identifying burn abuse. These are (1) immersion burn with or without spared area, (2) splash burn, (3) flexion burn and, (4) contact burn.

Immersion burns result when a child is forcibly held in a hot liquid. A uniform burn occurs in all areas exposed and a clear line of demarcation exists distinguishing areas of tissue exposed to the hot liquid and those not exposed. By positioning of the body, the demarcation lines can be made parallel, thereby allowing an estimate of the child's position at the time of immersion. In some forced immersion burns, doughnut-shaped patterns result with a central area of spared tissue. This pattern of burn injury occurs because the spared area is forcibly compressed against the bottom or sides of a container, thereby avoiding prolonged contact with the hot liquid. No area will be spared if the container of liquid is located on a heated element.

When the hot liquid is poured or thrown, splash burns result. The depth of splash burns is less than with immersion burns because the liquid cools as it falls and is in contact with the skin for a shorter period of time. The burn depths are nonuniform and there are often multiple noncontiguous burn areas. The force of gravity, as the liquid falls, produces an arrowhead configuration to the burn allowing an analysis of the position of the child's body and the direction from which the liquid came.

Accidental scald burns are usually asymmetrically distributed and only of partial thickness if treated promptly.[9] These burns are frequently on the front of the body caused by the child pulling over a container of hot liquid and some of the superficial splash burns are irregularly distributed.

Flexion burns occur when a burning agent is produced while the child's hips or other parts of the body are in flexion. A zebra-like striped configuration of the burn results because the flexed areas are protected from contact with the hot liquid. Areas commonly spared in this manner are creases anterior to the hip area and lower abdominal wall.

In contact burns, the burning agent such as a cigarette or iron is placed on the skin long enough to produce at least a second degree burn. In deliberate abuse, the configuration of the burn is that of the burning agent. In accidents, the contact agent is usually brushed against, thereby leaving an imperfect mark. For example, an accidental cigarette burn will not have the clear round shape of the abusive burn.

Information obtained during history-taking may assist the physician in determining the burn etiology. Often the parents' historical accounts of the injury will vary and may change over subsequent tellings. The parents may be evasive and the injury may be attributed to a sibling or babysitter. Frequently there is a delay in seeking medical care and often an unrelated adult brings the child for medical treatment. When a parent is present, he or she may display inappropriate concern or lack of concern for the child's condition. Finally, burn abused children appear passive, introverted and overly fearful.[7,18]

Location of burns • Locations of burns also aids the practitioner in identifying abuse. Immersion burns resulting in "stocking" or "glove" distributions occur when the extremities are forcibly held in hot liquid. These "mirror-image" burns are usually symmetrical and uniform in depth. While being held, the child is unable to splash, so satellite or noncontiguous burns usually are not present.[18] Several authors report a high incidence of abusive burns to the perineum and buttocks and these burns should be considered abuse unless otherwise proven.[2,18,21] Burns of the posterior aspects of the head, neck, chest and extremities are rarely self-inflicted and should arouse suspicion of willful injury.[1] The absence of a burn to the axilla or submental area with a history of the child pulling hot liquid over also requires extensive etiological investigation.

No consistent relationship between the extent of a burn and the etiology of abuse exists. It is noted, however, that death is more likely from abusive burns than from accidental burns.[9,15] First degree burns occur infrequently in burn abuse because the child is unable to remove himself from the burning agent resulting in longer exposure and a deeper burn. Two-thirds of the children in Gillespie's[1] sample had second degree burns while the remaining evidenced third degree. Tapwater scalds, regardless of etiology, tend to be more extensive than other scalds, involving approximately two times the mean body surface.[20]

Several additional characteristics of burn abuse are reported. A high incidence of previous injury in both the burned child and his siblings is noted.[1,7,11,13] Burn-abused children frequently present with multiple stigmata of abuse and neglect including burns of varying age. Bruising, fractures, damage to the central nervous system, and malnutrition are commonly associated with burn abuse.[1,13,16,18]

Errors in detection — False positives • While a heightened index of suspicion of abuse is essential to safeguard the welfare of children, the professional must explore all possibilities before a final determination of etiology is made. Five cases of suspected abuse described by Schmitt[22] were found to be accidental second degree burns which occurred when infants came into contact with surfaces heated by the sun. Several of the children were burned by vinyl upholstery and one was burned by the buckle of a bicycle safety strap. Dark-colored surfaces become as much as 30° hotter than light-colored ones when exposed to the same radiant sunlight.[22] In Florida, recent legislation has made it mandatory for infants and children less than age six to use some kind of seat restraint while in an automobile. The use of car seats by new parents in Florida and other sunbelt states may increase the incidence of car seat burns. Factors pointing to an accidental burn of this nature are the burn located on an exposed aspect of the body, history of dark colored seat upholstery and a recent auto or bicycle trip on a bright, sunny day. Further evidence of the nonabusive etiology of such burns is that parents seek medical care within a reasonable time period. Knowledge of the burning potential of items left in the sun is of importance to inhabitants of sunbelt states.

Cupping is noted to be a cultural etiology of burns.[23] In this instance, a heated glass was applied to several locations on the child's back as a medical folk remedy. Allergy to the cleanser Cetrimide is also found to present as nonaccidental burn injury.[24] Cigarette burns and bullous impetigo are similar in appearance. Cigarette burns, however, usually heal with a scar, whereas impetigo lesions do not.

False negatives • Failure to detect abusive burns can occur when the physician is not the initial caretaker. The practitioner may be loathe to intrude on the child after the burns have been bandaged. Due to the serious risk of abuse repetition, however, direct examination should be scheduled along with planned unwrapping. Pain medications given previous to the unwrapping will help to relieve the discomfort of both the child and physician. The examination should be repeated again in seven days to verify the well-known patterns.

Clinical experience leads us to estimate that etiology can be determined by physical examination in approximately two-thirds of the cases. These cases are about equally divided between abusive and accidental causes. The remaining cases require further evidence from the required home evaluations and psychosocial histories.

Demographic characteristics of children • The demographic characteristics of children with inflicted burns are similar to those found in other forms of mistreatment. Burns and burn abuse occur more frequently in boys than in girls. Stone[2] notes that 20 of 26 inflicted scald burns occurred in boys while Feldman[15] and Hight[7] report the incidence of burn abuse in boys to be twice that of girls. The modal age range of burned children is 13-24 months.[2,7] As with other forms of child abuse, psychological disturbances and physical defects may be consequential. The extent of physical scarring is dependent on the depth, location and extent of the burn. Multiple hospitalization for scar revisions and release of joint contractures may be necessary. Certainly the psychological trauma of a burn and the high incidence of associated battering in burn abused children can be expected to impact on their normal growth and development.[25]

Studies concerning emotional scarring of child burn victims are inconclusive.[26-29] Woodward[26] reports a follow-up study of 198 burned children showing a statistically significant (81% vs 14% in an unburned control group) incidence of emotional disturbances three years after recovery from the injury as reported by the mothers. Wright,[28] however, fails to show differences on a variety of psychological tests administered to burned children and a control group. Sawyer[29] finds that adolescent burn victims evidence poorer psychosocial adjustment than do younger children. The authors caution that even an apparent good adjustment by a young child does not preclude later emotional problems, especially during the tumultuous adolescent years.

No studies of emotional scarring of burn-abused children are published. In the hospital, however, these children appear passive, introverted, and fearful of incurring further injuries from strangers. They tend to remain withdrawn in their beds and do not seek contact with the other children. They exhibit a flattened effect and do not generally cry or resist their treatments. Initially these children are unresponsive to friendly overtures by the staff but over time, as trust develops, dramatic changes in their responsiveness are seen.[7]

Demographic characteristics of the parents • The demographic characteristics of the parents of burn-abused children also are similar to those described for other types of abuse. The problem is not confined to the poor but crosses all socioeconomic levels.[1] Feldman[15] and O'Neill[4] report, however, a higher incidence of scald burns among the lower socioeconomic groups. While Lauer[11] notes more abuse occurring in white families, most studies do not find race to be a factor in willfully inflicted burns.

Often environmental and psychiatric stress are antecedents to childhood burns and accidents.[30,31] Hight[7] finds the majority of families to be single (48%) or divorced or separated (27%). Severe marital stress is noted in all of the cases of burn abuse

reported by Ayoub and Pfeifer.[16] Maternal characteristics include isolation, suspiciousness, rigidity, dependence, immaturity and a lack of empathic mothering. Burn abuse families are more likely to be excessively mobile, have histories of employment difficulties and of violence in the home.[16] Alcohol and drug abuse are found to be associated with burn abuse.[1] While Keen[21] remarks on the possibility of parental mental illness due to the heinous nature of burn abuse and Gillespie[1] notes manifest psychosis in eight of the abusing parents, most studies do not find mental illness to be a predisposing factor to burn abuse. In the hospital, abusing parents reveal inappropriate or detached emotional concern for the child. Frequently they abandon the child after admission and use the telephone to check on the child's condition. Failure to seek immediate medical care for the burned child also has been noted as a characteristic behavior of abusing parents.

Discussion • The repetitive nature of burn abuse in association with other forms of maltreatment without intervention places a child at high risk for further injury and even death. Recognition of inflicted burns requires astute professionals with a high index of suspicion and the performance of a careful history and physical examination. The exact details of the incident should be recorded and considered with a critical assessment of the depth, extent and distribution of the burn along with the developmental age of the child. A detailed developmental history will assist the physician to ascertain whether the child is developmentally mature enough to have caused the injury. Analysis of the depth, configuration, distribution of the burns, and the reciprocal relation to flexion creases and joints of the spared areas may allow for the detection of the body position at the time of the burn occurrence.[13] This information is a powerful tool for assessing the accuracy of the history and the likelihood of abusive etiology.

During the physical examination, careful inspection of not only the burn area but also the entire body is required. Frequently other stigmata of abuse and neglect will be present as well as recent hand or fingerprint bruises received while the child was being forcibly held. A skeletal survey should be performed to inspect for the existence of fractures.

Criteria for detecting the battered, burned child have been defined from the most common physical, historical and social findings.[7]

Physical findings:

1. History of burn incompatible with physical findings,
2. Burn incompatible with developmental age of the child,
3. "Mirror image" burns of the extremities,
4. Localized burns of the perineum, genitalia, and buttocks,
5. Burn assessed as older than historical account,
6. Unrelated hematomas, lacerations, fingernail marks and scars,
7. Unsuspected old, long bone or skull fractures found on skeletal survey.

Historical and social information:

1. Burn attributed to siblings,
2. Unrelated adult seeking medical treatment for the child,
3. Differing historical accounts of the burn,
4. Treatment delay of longer than 24 hours,
5. History of numerous prior accidental injuries,
6. Inappropriate or lack of parental concern,
7. Passive, introverted, fearful child.

When the history and physical findings suggest an inflicted burn, the law mandates a report of suspected abuse to the Florida State Child Abuse Registry. Unfortunately, professionals often are reluctant to report suspected abuse; perhaps because they are concerned about making moral judgments, increasing parental distress, and/or having to deal with increased tensions, hostility and manipulation from the parents once the report is made. Legally the report should be made as soon as abusive etiology is suspected. The report should be discussed with the family in a nonjudgmental fashion and its purpose of protecting the child explained. The professional should detail for the family what happens after the report, beginning with the investigatory visit from Department of Health and Rehabilitative Services staff. Acknowledging in a nondefensive manner the anger often expressed by parents may help to defuse the situation.

An intensive history of the injury, careful physical examination, and investigation of social characteristics are essential to burn abuse detection. By comparing the probable mechanism of the burning with the history and the developmental skills of the child, the practitioner can determine the etiology of the burn. Child abuse without intervention tends to be repetitive. When the abuse is repeated, the severity of the injuries always escalates over time. Given the vulnerability of young children, the professional must develop a high index of suspicion when treating burned children. When abuse is suspected, the practitioner must notify HRS and take the appropriate steps for intervention.

Acknowledgment

We would like to express our appreciation to Pat Lyons and Karen Garrett for their assistance in the preparation of the manuscript.

References

1 Gillespie, R.W.: Battered Child Syndrome: Thermal and Caustic Manifestations, Trauma 5(4):S23-S34, 1965.
2. Stone, N.H.; Rinaldu, L.; Humphrey, C.R., and Brown, R.H.: Child Abuse by Burning, Surg. Clin. Am. 50(6):1419-1424, 1970.
3. Smith, S.M. and Hanson, R.: 124 Battered Children: Medical and Psychological Study, Br. M. J. 3:666-670, 1974.
4. Ryan, M.G.; Davis, A.A., and Oates, R.K.: One Hundred and Eighty-Seven Cases of Child Abuse and Neglect, Med. J. Aus. 2:623-628, 1977.
5. Lung, R.J.; Miller, S.H., Davis, T.S., and Graham, W.P.: Recognizing Burn Injuries as Child Abuse, Am. Fam. Physician 15(4):134-135, 1977.
6. Fowler, J.: Child Maltreatment by Burning, Burns 5:83-85, 1978.
7. Hight, D.W.; Bakalar, H.R., and Hoyd, J.R.: Inflicted Burns in Children, JAMA 242(6):517-520, 1979.
8. Bakalar, H.R.; Moore, J.D., and Hight, D.W.: Psychosocial Dynamics of Pediatric Burn Abuse, Health Social Work 6(4):17-32, 1981.
9. Shaw, A.: Surgical Management in Child Abuse, In E.H. Newberger (ed), Child Abuse, Boston, Little, Brown and Co., 177-206, 1982.
10. Mercer, D.M.: Cetrimide Burn in Infant, Postgrad. Med. J. 59:472-473, 1983.
11. Lauer, B., Broeck, E.T., and Grossman, M.: Battered Child Syndrome: Review of 130 Patients with Controls, Pediatrics 54(1):67-70, 1974.
12. Lenoski, E.F. and Hunter, K.A.: Specific Patterns of Inflicted Burn Injuries, J. Trauma 17(11):842-846, 1977.
13. O'Neill, J.A.; Meacham, W.F.; Griffin, P.P., and Sawyers, J.L.: Patterns of Injury in Battered Child Syndrome, J. Trauma 13(4):332-339, 1973.
14. Springthorpe, B.J.; Oates, R.K., and Hayes, S.C.: Nunaccidental Childhood Injury Presenting at Hospital Casualty Department, Med. J. Aus. 2:629-632, 1977.
15. Feldman, K.W.; Schaller, R.T.; Feldman, T.A., and McMillon, M.: Tap Water Scald Burns in Children, Pediatrics 62(1):1-7, 1978.
16. Ayoub, C. and Pfeifer, D.: Burns as Manifestation of Child Abuse and Neglect, Am. J. Dis. Child. 133:910-914, 1979.
17. Glasheen, W.P.; Attinger, E.O.; Anne, A.; Haynes, B.W.; Heibert, J.T., and Edlich, R.F.: Identification of High-Risk Population for Serious Burn Injury, Burns 9(3):193-200, 1983.
18. Jewett, T.C. and Ellerstein, N.S.: Burns as Manifestation of Child Abuse, In N.S. Ellerstein (ed), Child Abuse and Neglect, New York, John Wiley and Sons, pp. 185-196, 1981.
19. Mortiz, A.R. and Henriques, F.C. Jr.: Studies of Thermal Injury: II. Relative Importance of Time and Surface Temperature in Causations of Cutaneous Burns, Am. J. Path. 23:695-702, 1947.
20. Feldman, K.W.: Help Needed on Hot Water Burns, Pediatrics 71(1):145-146, 1983.
21. Keen, J.H.; Lendrum, J., and Wolman, B.: Inflicted Burns and Scalds in Children, Brit. Med. J. 4:268-269, 1975.
22. Schmitt, B.D.; Gray, J.D., and Britton, H.L.: Car Seat Burns in Infants: Avoiding Confusion with Inflicted Burns, Pediatrics 62(4):607-609, 1978.
23. Sandler, A.P. and Haynes, V.: Non-accidental Trauma and Medical Folk Belief: Case of Cupping, Pediatrics 61(6):921-922, 1978.
24. Inman, J.K.: Cetrimide Allergy Presenting as Suspected Non-accidental Injury, Br. M.J. 284, 38S, 1982.
25. Gregg, G.S. and Elmer, E.: Infant Injuries: Accident or Abuse, Pediatrics 44(3):434-439, 1969.
26. Woodward, J.: Emotional Disturbances of Burned Children, Br. M. J. 1:1009-1012, 1959.
27. Lung, R.T. and Cope, O.: Emotional Problems of Burned Children, N. England J. M. 264(22):1121-1127, 1961.
28. Wright, L. and Fulwiler, R.: Long Range Emotional Sequelae of Burns: Effects on Children and Their Mothers, Ped. Res. 8:931-934, 1974.
29. Sawyer, M.G.; Minde, K., and Zuker, R.: Burned Child — Scarred for Life? Burns 9(3):205-213, 1983.
30. Feldman, K.W.: Child Abuse by Burning, In H. Kempe and R. Helfer (eds), The Battered Child, U. of Chicago Press, pp. 147-162, 1980.
31. Meyer, R.L.; Ruelofs, H.A.; Bluestone, J., and Redmond, S.: Accidental Injury to Preschool Child, J. Pediatr. 63:95-105, 1963.

● Ms. Watkins, 84 Adalia Avenue, Tampa 33606.

The abuse of infants by manual shaking: medical, social and legal issues

Barbara A. Eagan, M.A.; Susan Whelan-Williams, B.S.W.; and William G. Brooks Jr., M.D., M.P.H.

ABSTRACT: In the early 1970s Caffey comprehensively presented the pathogenic nature of the manual shaking of infants to the pediatric community. The Whiplash Shaken Infant Syndrome (WSIS) has since received coverage in numerous publications. Experiences indicate that discrepancies appear in the interdisciplinary methodologies for managing such cases. Comparison is noted of observable variances in the management of cases of WSIS and typical child battering. The need for thorough multidisciplinary/interagency evaluation of all recognized cases of WSIS is discussed in conjunction with presentation of medical and psychosocial diagnostic criteria for WSIS secondary to child abuse. Relevant legal, medical and psychosocial issues are highlighted based on the observations and experiences of members of a hospital-based, multidisciplinary child protection team.

The Authors
BARBARA A. EAGAN, M.A.
SUSAN WHELAN-WILLIAMS, B.S.W.
WILLIAM G. BROOKS JR., M.D., M.P.H.
Ms. Eagan is a Case Coordinator/Training Coordinator; Ms. Whelan-Williams is the Program Coordinator, Orlando Regional Medical Center Child Protection Team, and Dr. Brooks is a Resident in Pediatrics, Orlando Regional Medical Center.

The Whiplash Shaken Infant Syndrome (WSIS) received the attention of professionals involved in the diagnosis and treatment of abused children in 1974 when John Caffey, M.D., published a landmark article in *Pediatrics*. Diagnostic criteria for pathogenicity of manual shaking in the whiplash syndrome were defined as "the most characteristic pattern of physical findings where there is no external evidence of trauma to the head, soft tissue of the neck and face of the facial bones and calavaria in conjunction with massive traumatic intracranial and intraocular bleedings."[1,2] In the ten intervening years since Caffey's publication, numerous reports have appeared in journals and the syndrome has received coverage in most anthologies on battered children.[3-7] Experience shows, however, that professionals in medicine, social science, criminal justice and law enforcement are hesitant to recognize shaking as an act of child abuse when perpetrated by a parent or designated caretaker. Most commonly, injuries received from shaking seem to be regarded as a sign of parental ignorance concerning the anatomical configuration of the infant head and neck rather than as a culpable act. Infants presenting with severe injury from acceleration/deceleration trauma are often viewed by the local state child protection agency and the juvenile and criminal justice systems as only slightly more in need of protective services than children who are injured accidentally, where the issue of parental negligence is so negotiable that only cursory intervention is routinely provided. Cases where injuries are the result of slapping or striking with an object (often with less severe physical sequelae for the child) are many times more aggressively pursued. Parent education is often proposed as a method of preventing similar injury. Periodically brief media campaigns are launched to

focus public attention on the danger of shaking very young children as a disciplinary tactic or attention-getting device. Certainly such educational pursuits are to be lauded, but are they enough? Are parents, who cause potential permanent injury to their children by shaking, themselves victims of a society which allows us to develop child rearing skills by trial and error, or do they fit the recognized characteristic pattern of persons prone to commit serious abusive acts toward children?[8] The implied debatability of these philosophies has led to major difficulties in development of acceptable management plans in several recent central Florida cases. It is our intent to document perceptions of the dilemma and the impact differing perceptual bases may have on treatment plans when compared with those developed by children who have suffered injury from other forms of inflicted trauma. The provision of concrete examples should provide impetus for future investigation and resolution of the issue.

As members of a hospital based, multidisciplinary child abuse team, we are involved in evaluation of approximately 100 children per month alleged to have been abused by caretaking adults. Assessment includes comprehensive medical and psychosocial evaluation, provision of treatment recommendations, and coordination of communication between the statutorily designated investigative parties (i.e. H.R.S. caseworker, law enforcement investigator, state attorney investigator and guardian ad litem). Formal information sharing and case planning staffings are done whenever there are differing opinions concerning treatment which cannot be resolved on an informal basis, and/or when case plans appear inadequate for protection of the child and treatment of the family. Such interagency meetings are required in WSIS cases far more often than in cases indicative of other types of inflicted trauma, although the prognosis for permanent damage is often more significant in the former than the latter. It has been our experience that the issue of culpability and intent seems to be consistently raised during discussion of WSIS but rarely raised when debating a course of action for other types of child battering.

Based on our observations, successful child protection and family treatment usually warrant intervention of both juvenile and criminal court systems when the inflicted injury is severe and the parents deny (or rationalize) their responsibility for the child's injury.[9,10] Voluntary plans seem to prove ineffective in these cases leaving the child at risk for reabuse. Research must be initiated to provide more than a hypothetical basis for such an argument. However, recent findings on husbands who abuse their wives indicate that recidivism is decreased when criminal charges are pressed by the victim.[11] We contend that the child with severe intracranial trauma resulting from manual shaking frequently fits both legal and sociomedical definitions of an abused child. Careful history taking will usually reveal intra-family dynamics identical to those found in other abusive families (e.g. low stress tolerance, generational pattern of abnormal child rearing practices, marital discord, and unrealistic expectations for children). The following section will present brief studies of two cases of shaken children and two cases of children injured by other means with presentation of physical findings, family dynamics and case plans. Discussion will focus on differences with implication for medical, legal and social case management, as well as on the need for development of a consistent conceptual base for the handling of WSIS by the various disciplines involved.

Case reports — Case 1 • This 11-month-old female presented to the emergency room after she was found lying on the floor comatose and in respiratory arrest. Initial physical examination was unremarkable except for bilateral retinal hemorrhages on funduscopic examination. A head CT scan revealed a subarachnoid hemorrhage. State child protective services and law enforcement agencies were notified; the multidisciplinary team was also consulted. The father reported that while in his care the child had fallen from a couch and was found unconscious.[12] The child's past medical history was unremarkable for serious illness; however, there was a history of several injuries during the month prior to hospitalization consisting of linear facial bruises covering the left cheek and ear (parent explained child fell from bed); two large bruises on the buttocks and lateral thigh (parent explained she fell on a supermarket scale); and a large area of soft tissue swelling on the forehead (also reportedly from a fall). During the child's hospitalization, the stepfather admitted that he had "shaken" the child to wake her up from a nap in an attempt to adjust her sleep schedule, and "slapped" the child to gain her attention.

The stepfather presented a history of childhood poverty, relocation and physical abuse. He prematurely quit high school to assist with family finances as both of his parents were disabled. Psychometric evaluation (MMPI) revealed a profile consistent with those of individuals possessing low stress tolerance and impulse control. The mother reported a childhood with many relocations, parental alcoholism and spouse abuse, maternal child abuse and parental divorce. She stated that, as an adolescent, she felt "unwanted," became involved in delinquent activities, and experienced an unplanned pregnancy which was terminated by abortion. She met and married her present husband only after giving birth to a daughter. Both parents reported marital disharmony, financial problems and significant discord in extended family relationships. At the time of referral the mother was in her third unplanned pregnancy.

The state child protection worker was hesitant to initiate juvenile court proceedings and felt that the family could be assisted through a voluntary plan. In addition, the law enforcement investigator refused to file criminal charges. A multidisciplinary staffing was called to discuss case plans. The potential for reinjury of the child was stressed by hospital team members by linking the serious nature of presented injuries, history of questionable accidents and the significant correlation of the parents' psychosocial profile with that of child abusing adults. State and law enforcement officials felt that the child could be protected through a short stay in shelter care while the parents initiated individual counseling and parenting education.

There was marked debate concerning the efficacy of such a plan. However, the child remained in shelter care for two months and was returned home under sporadic agency supervision.

A second referral was received two months later when the child was brought by paramedics to the emergency room lethargic and unresponsive to verbal commands. Radiographic studies revealed an acute subarachnoid hemorrhage coinciding with a four to five-day-old bruise on the left temple. Funduscopic examination revealed acute bilateral retinal hemorrhages. The stepfather reported that he became "angry" with the child after a toilet accident and "spanked" her. In an effort to comfort her, he "played" with her by "spinning her around" and subsequently noticed the child to be unresponsive and unable to stand on her own. She was removed from the parents and placed with her grandparents. State officials initiated civil procedures for severance of parental rights and criminal charges were filed against the stepfather.

Case 2 • This 7-year-old male presented to the emergency room by the state child protection worker with injury to his right buttock and thigh. The multidisciplinary team was contacted for evaluation. Acute bruises were noted to cover the child's buttocks and lateral right thigh with markings showing the clear delineation of a belt end; ten to 12 separate marks could be counted. The child's two younger brothers (ages two and five) were noted on physical examination to have less severe, though similar, marks to the buttocks. The child reported that on the evening prior to his emergency room visit he had lost a small digital clock and was hit with a belt, in his mother's presence, by her male companion. He stated this was one of many similar whipping episodes from his mother and her boyfriend. No signs of chronic trauma were noted.

Social history revealed multiple factors giving a generalized picture of family instability. The mother stated that this child presented "severe behavioral problems" and admitted using belts for discipline. Both the mother and boyfriend revealed a childhood history of physical abuse.

The children were taken into custody by the state agency and remained in care throughout juvenile court proceedings, subsequently returning home. Intensive in-home crisis counseling, individual counseling, agency supervision and parent education were provided. The boyfriend was arrested and charged with aggravated child abuse.

Case 3 • This 10-month-old male presented to the emergency room by paramedics who found the infant at home unconscious and in respiratory distress. A CT scan of the head revealed bilateral subdural and subarachnoid hemorrhages. Funduscopic examination revealed acute bilateral retinal hemorrhages. The state child protection worker was then notified along with the multidisciplinary team. The father reported that during the day of admission the child had been in his care and was placed in an armless chair while he (the father) lay down for a nap. He awoke to find the infant "crying, lodged between the couch and an end table." The baby was "placed back in the chair" and the father "left" the room. He again "heard crying" and stated the child appeared to have once more "fallen from the chair." Upon further questioning he indicated that he attempted to calm the child by shaking him back and forth. Radiological studies during the hospital course showed a healing fracture of the left radius and ulna. The child expired on the third day of hospitalization.

Evaluation of the siblings revealed healed loop marks on the legs of the four-year-old who was present with the father on the date of the case subject's injury. The sibling was questioned as to what occurred with his brother and stated that "Daddy killed him."

Psychiatric evaluation of the father revealed a history of chronic schizophrenia resulting in prior hospitalization. Outpatient treatment included administration of psychotropic medication. The father denied conscious memory of his childhood. The mother reported a steady employment history and a strong extended family support system. She reported previous violent acts by her husband toward herself and the children. She indicated that her husband was easily frustrated.

Initally state child protection officials and prosecutors were hesitant to initiate civil and criminal proceedings as they viewed the injury as unintentional and the result of poor judgement. An interagency staffing was held where the multidisciplinary team physician and medical examiner noted the injuries to be inconsistent with a fall and more consistent with shaking trauma.

The case was then presented to juvenile court and a plan of child protection involving the surviving siblings was ordered. The father was charged with second degree murder and pleaded guilty to the lesser crime of manslaughter; he received a seven year sentence.

Case 4 • This 2-year-old white female presented with circular area of several day old bruising covering her buttocks with linear bruising of the right lateral thigh. Child protection officials and law enforcement were contacted as well as the hospital-based multidisciplinary team. The mother stated the child had been left at a babysitter's home several days prior to the referral and due to a family emergency, the child was then cared for by an older female in the neighborhood. When the mother took back her child, she was noted to have a reddish swelling on both buttocks extending to the knees on the lateral aspect of her right thigh. The initial babysitter was questioned and revealed she had left the child with a neighbor during the day, who struck her with a wooden kitchen spoon for misbehavior. The babysitter readily admitted to striking the child and stated she did not realize she was "such an easy bruiser." Laboratory coagulation studies were within normal limits.

State officials investigated the babysitter's home situation and reported further action to be outside their jurisdiction (as the perpetrator was a nonrelative). The sitter, an older woman, was criminally charged with aggravated child abuse.

Eventually charges were reduced to misdemeanor battery during plea bargaining. The sentence included a course of probation, community service and a fine.

Discussion • Comparison of the four case studies makes it obvious that state child protection and criminal justice officials were hesitant to provide comprehensive intervention in the two cases of WSIS even though in both cases injuries were quite severe. In contrast, are the two cases of child battering involving older children who sustained bruises to the buttocks and thighs as a result of whippings by instrument (i.e. belt and wooden spoon) with less severe physical sequelae. Those cases were aggressively pursued, with family members receiving intensive therapeutic services and the offenders receiving criminal sentences. It should also be noted that cursory examinations of the two battering families

were undertaken with the presenting injuries seeming to be sufficient for intensive agency action. Conversely, both families in which the child presented with WSIS were intensely evaluated and evidence of abusive familial dynamics was significant (e.g. marital turmoil, prior history of violence, financial difficulties, low stress tolerance, and emotional instability). However, even in light of the combined factors, intensive advocacy was needed by the children's examining physician and other team professionals to insure an adequate plan of protection was initiated for the child. Certainly the aforementioned situations are not always exemplary of case action but such a scenario occurs with alarming frequency in cases of WSIS.

Summary • The Whiplash Shaken Infant Syndrome is a form of child abuse that presents multiple issues which must be addressed by those providing diagnostic and treatment services to children. The incidence of injury from manual acceleration/deceleration trauma is difficult to assess as many cases may go unrecognized. Those which are documented often appear to be associated with other forms of physical abuse (physicians' reports have ranged from 20 cases in five years to 20 in one year).[13] Published estimates indicate that 70% of the victims of WSIS either die or suffer permanent gross residual damage.[13] Caffey reports that acceleration/deceleration of the head of an infant is the most frequent cause of intellectual impairment and brain damage.[1] Any patient presenting to the physician with a history of convulsion and/or coma, evidence of intracranial and intraocular trauma in conjunction with a lack of visual signs of injury should be considered abused until proven otherwise. Physicians should insure that the child receives the benefit of medical care, thorough psychosocial assessment of family members, legal intervention and a multidisciplinary case plan. It is imperative that cases of WSIS be pursued in a comprehensive manner. If such an approach is ignored, the child will remain at risk for reinjury in many instances.

It appears that the most common motivation for the shaking of small children is the effort to discipline a child for actual or perceived misbehavior.[1] Many persons erroneously view such disciplinary tactics as more appropriate than striking children. However, any parental discipline which results in emotional or physical injury to a child is commonly recognized as symptomatic of abuse. Florida law requires physicians (and other persons) having reason to believe a child is abused to report such suspicions to the Department of Health and Rehabilitative Services. A failure to tender such reports is a misdemeanor.[9] Reporting suspected abuse provides impetus for a child protection investigation and thorough psychosocial assessment of family members. Those mandated to investigate allegations of possible abuse, in turn, instigate a criminal investigation by contacting law enforcement. Criminal justice officials concurrently determine if perpetrators have violated misdemeanor or felony statutes. Several investigative factors, relevant to cases of WSIS, should be discussed. Histories presented by caretakers during initial assessment are often inconsistent with the clinical picture. It is quite common to receive conflicting explanations concerning the etiology of the child's injuries, and it is not uncommon for explanations to change during the course of investigation. Presentations of multiple and inconsistent explanations, coinciding with dysfunctional family dynamics and medical evidence of trauma to the child, constitute a portion of the evidence for civil and criminal child abuse. The case studies in the foregoing portion of this paper provided concrete examples of such. Inconsistencies in statements can be presented as a factual base for the establishment of intent during court proceedings.[14] The use of subterfuge by the parent provides an argument that the perpetrator did, in fact, consciously understand that his actions could result in harm to the child.

The suggestion of an accidental component to WSIS is not without merit. Indeed, a number of cases reported could be classified as such and are thought to be the result of, for example, unsafe play procedures (such as rapid windmill swinging and tossing of infants) or an attempt to dislodge an object from a child's throat.[1] Although the aforementioned examples would probably not be classified as intentional abusive actions, they indicate a need for comprehensive educational conferences with the caretakers (a primary responsibility of persons who routinely deal with parents). In addition, Hispanic folk medicine practices have been documented in which a sunken fontanelle is treated by holding an infant upside down, with the head partially immersed in boiling water, slapping the soles of the feet and shaking.[15] The physician is not solely responsible for determining whether an injury resulting from manual shaking is accidental or abusive in nature. Other pertinent factors must be considered by the statutorily mandated investigating parties before an ultimate decision can be reached.

In conclusion, we suggest that WSIS secondary to abuse must be the initial diagnosis of exclusion in cases where overt head trauma is absent but is then discovered upon further examination in the form of head CT scan, funduscopic examination, etc. Routine funduscopic examinations should be included in all pediatric examinations and provide an excellent screening device for the timely diagnosis of WSIS.[1] A legitimate comprehensive approach requires thorough medical, psychosocial, and legal evaluation.

We contend that the shaking of infants and children is a serious form of child abuse and calls for recognition and aggressive intervention.

References

1. Caffey, J · Whiplash Shaken Infant Syndrome: Manual Shaking by Extremities with Whiplash Induced Intracranial and Intraocular Bleedings, Linked with Residual Permanent Brain Damage and Mental Retardation, Pediatrics 54-4:396-403, 1974
2. Caffey, J.: On Theory and Practice of Shaking Infants. Its Potential Residual Effects of Permanent Brain Damage and Mental Retardation, Am. J Dis. Child 124 161-169, 1972.
3. Morse, C W.; Sahler, O J , and Friedman, S B : A Three Year Follow-Up Study of Abused and Neglected Children, Am. J Dis. Child 120:439-446, 1970.
4. Bennett, H.S. and French, J.H · Elevated Intracranial Pressure in Whiplash-Shaken Infant Syndrome Detected with Normal Computerized Tomography, Clinical Pediatrics 19-9:633-634, 1980
5. Oliver, J E . Microcephaly Following Baby Battering and Shaking, Br M J 2:262-264, 1975.
6. Guthkelch, N Infantile Subdural Hematoma and Its Relationship to Whiplash Injuries, Br M. J. 2:430-431, 1971
7. Ellerstein, N , (ed): Child Abuse and Neglect, A Medical Reference, John Wiley & Sons, Inc., pp 74-75, 1981
8. Martin, H The Abused Child, Ballinger Publishing Company, pp 27-41, 1976
9. Florida Statutes, Volume 2, Chapters 316-560. Ch 415, Protection From A' 'se, Neglect and Exploitation, 415.504; 415 503, 918-919; 415.511; 921-922, 415 513, 922, 1983.
10. Florida Statutes, Volume 3, Chapters 561-960. Ch 827, Abuse of Children or Disabled or Aging Adults, 827.03, 827.04, 1393, 1983
11. O'Reilly, J . Wife Beating. The Silent Crime, Time 23-26, September 5, 1983
12. Helfer, R.E.; Slovis, T L., and Black, M Injuries Resulting When Small Children Fall Out of Bed, Pediatrics 60-64 533-535, 1977
13. Curran, M · Shaken-Infant Syndrome "Secret" Form of Child Abuse, Pediatric News 19-26, 1984
14. Black's Law Dictionary, Revised 4th Edition 947, West Publishing Co.
15. Guarnaschelli, J.; Lee, J., and Pitts, F . Fallen Fontanelle· (Caida de Mollera) A Variant of the Battered Child Syndrome, JAMA 222-12 1545-1546, 1972.

Acknowledgment

We extend our appreciation to Doris Webber and Lavonna Newsome for their assistance in manuscript compilation and Danny Dawson, Assistant State Attorney, Juvenile Chief, for his comments on legal issues. This manuscript was funded in part by the Department of Health and Rehabilitative Services, Children's Medical Services.

● Ms. Eagan, Orlando Regional Medical Center Child Protection Team, 85 West Miller, Suite 304, Orlando, Florida 32806.

The incestuous family: profile and treatment plan

James J. Arnone, A.C.S.W., L.C.S.W. and Lawrence R. Leviton, M.D.

ABSTRACT: Incest in the family is a rapidly growing problem. The patterns of these families are different from those of families where other types of child abuse occur. These patterns are described. Effective treatment must include the entire family and coordination among the various agencies providing service. The conclusion recommends establishing specific laws for this abuse which will protect the child and allow for treatment of the offender and the entire family.

The Authors
JAMES J. ARNONE, A.C.S.W., L.C.S.W.
LAWRENCE R. LEVITON, M.D.
Mr. Arnone is Team Coordinator for the Child Protection Team, Inc., Riviera Beach, and Dr. Leviton is Medical Director.

Incest occurs when the parent, usually a father, uses his position of trust and authority to introduce the child into a secret sexual relationship. This often begins as a private game and progresses with exposure, kissing, genital fondling, and finally, but not necessarily, sexual intercourse.[1] Most cases coming to our attention involve fondling prior to intercourse. The sexual relationship has many "caring aspects" and is not primarily aggressive.

Legally defined, incest specifically describes intercourse with persons of close blood lineage. For treatment purposes, it may include stepfather, stepmother, stepbrothers and others with well established social ties. It may also include an array of sexual activity with the child. "The relationship is longstanding, with the adult having achieved a position of authority in the child's family as manifested through his active participation both in the family's decision making and their division of labor."[2]

Incidence • Estimates vary substantially regarding the exact incidence of incest and child sexual abuse. According to various researchers, "somewhere between 100,000 and 500,000 American children will be molested this year."[3] Most professionals agree that about one in four girls and one in ten boys are sexually abused in some way prior to their 18th birthday. The smallest proportion of child sexual abuse is made up of sexual contacts with strangers or less intimate family members. Eighty percent of abuse involves parents, usually the father, or other trusted relative and falls into the category of incest.[4]

Our experience in Palm Beach County where the treatment program has been in existence for more than two years shows a steady increase from six cases per month to a current average of 17; 580 families have been involved. The incestuous family

is in all socioeconomic groups, racial and religious backgrounds. Typically both parents are employed. Seldom is a member of the family known to any social or law enforcement agency.

Characteristics • A common characteristic of the families is social isolation. They have few community contacts. Contacts that do occur tend to be narrowly defined, for example, church or work related. These families tend to be mistrustful of "outsiders." The children are not encouraged to interact freely with friends and classmates. One mother vividly described her home as a "cocoon" which was seldom entered by those from the outside.

The incestuous adult tends to be socially timid and mistrustful. The men typically have low self-esteem and lack a sense of masculine identity. They try to compensate by projecting an image of male dominance. This results in tight controls and domination of both wife and children.

The communication patterns and sexual relationship of the husband and wife are unsatisfactory. Other factors may be involved including poor health, substance abuse, and minimal to absent sexual activity with the spouse. When both parents are employed, there are often different working schedules. This results in the father being left alone with the children.[5] He turns to one of the children, usually a daughter, in a desperate need for intimacy and control of his life.

The child may tell her mother. Some mothers reassure the child that they will discuss this with the father. Their interventions are ineffective. The mother may also fear risking a confrontation. The child soon realizes that she has no ally within her family. The mother continues to absent herself from her family believing the father's promise that he has stopped his sexual advances.

The sexual advances are bewildering to the child and usually the incestuous adult cajoles or frightens the child into secrecy. The inappropriateness of the situation is sensed by the child and progressively she fears disintegration of her family, fear of rejection of her friends, school, and finally the community. Often the relationship goes on for a period of years before she can tell a third party.

When the sexual abuse is finally revealed to law enforcement and child protection agencies, the mother expresses shock and disbelief. In many cases the father wants to be seen as a victim of the child's sexual advances. The parents often portray the child as seductive and sexually precocious.

Once the report is made, decisive external intervention is needed to break the control the perpetrator maintains over the family. The child must be reassured and the offender should be physically separated from the family. A coordinated intervention by professionals and agencies is essential. In most communities several agencies are involved with reports of child sexual abuse. These include: law enforcement, Department of Health and Rehabilitative Services (HRS), Sexual Assault Assistance Program, State Attorney's Office, and Child Protection Team.

Professionals must coordinate their intervention to reduce the trauma for the child. Instead of multiple interviews of the child, one planned (and ideally videotaped) interview is desirable. A physical examination should be provided if there is any indication of trauma to hymen and genitalia, possible venereal disease or pregnancy.

Due to secrecy of incestuous relationships, absence of witnesses and lack of physical evidence, these cases are rarely successfully prosecuted in a criminal trial. Moreover, the strong emotional and social ties between the offender and child will often increase the child's reluctance to testify against her father. Most children simply want the abuse to stop, to get relief from the emotional coercion she feels and help for her father and family.

Treatment • Because incest is most often symptomatic of severe family pathology, it should be treated through counseling.[6] We have found that the courts must be involved as an initial motivator for the family to enter treatment and to break the control the father holds over the family. Strong criminal sanctions such as imprisonment must be the consequence of noncompliance with treatment and other conditions of probation.

Treatment for the incestuous family must involve each member. We found that the key to success is counseling for the mother-daughter relationship. The mother is torn in her loyalties between her husband and child. There are also feelings of competition and guilt for not being more protective. This guilt is increased with mothers who had prior knowledge and did little to stop the involvement or did not believe the child.

The goals for the offender involve his accepting total responsibility, understanding of the reason for his behavior, and willingness to change his position of dominance in the family. If treatment is successful, he will be able to continue financial and emotional support of his family.

The goals for the child include development of more positive attitudes towards her own sexuality, and resolving her conflicting emotions regarding herself (as a victim), the offender, and her mother, who was not there when she needed her.

For the mother, the goals include sorting out her own feelings of guilt regarding development of the incestuous relationships. The mother must also resolve her ambivalent feelings toward her husband and daughter, and in the words of one mother, "get back my child again."

The siblings must understand their sister's innocence and not hold her responsible for the turmoil in the family. Finally the parents must come to resolution regarding the future of their family.

We have found that a planned sequence of therapies is needed to achieve these outcomes. These include: individual counseling for the child, mother and father; mother-daughter counseling; marital counseling if appropriate; father-daughter counseling; family counseling, and group counseling.

Case report • Susan is the 11½-year-old natural child of Ed and Barbara, the oldest of three children.

For the past three and a half years, the father admitted to fondling the child and kissing her between her legs. This act was discovered when the mother entered the bedroom and found her husband in bed with the child. She immediately reported the case to HRS and the Child Protection Team, Inc.

The father shows an employment history of many short-term jobs, and some alcohol abuse. He has low self-esteem. His relationship with his wife is poor and his behavior is impulsive. Since discovery of the incident, he accepts responsibility for his behavior but minimizes any effect it has had on the child. He stated, "She was sleeping when I fondled her." Barbara's initial response was of shock and anger. Initially she was unsure about ever seeing her husband again. Since she has been in treatment, she feels that her husband needs help and wants to emotionally support both him and her daughter.

At this time, the child is undergoing individual therapy and simultaneously the parents are involved in family therapy.

The father awaits sentencing and has been ordered into treatment which is focused on irresponsible behavior and on trying to understand the reasons for his dangerous and unlawful actions.

Ed has been court ordered out of the home. For any reunification to occur, marital/family therapy will have to continue until it is felt safe and desirable for family unit to come together again.

Program results • There have been 119 families in our treatment program since March 1983. Three offenders were sentenced to prison despite involvement with the program. In each of these cases the abuse was particularly damaging to the child. In addition, one offender decided on prison as opposed to community based counseling. His wife, however, has continued in the program.

Of the total families involved in treatment there have been three subsequent reports of a remolest of the child. Upon careful law enforcement investigation, two were found unsubstantiated. The third was valid and he has been returned to prison.

Unfortunately not all families enter treatment. Several factors contribute to this failure. We have observed two recurring themes. The first is the lack of coordination among agencies mandated to intervene in these situations. Without careful coordination, the child will feel confused, overwhelmed and not believed. She will feel that her desire for help is not forthcoming and will end involvement of these agencies by changing her story.[7]

The second factor affecting treatment is the application of laws such as "lewd assault" and "sexual battery" to the incestuous relationship. These laws connote violence, a sudden forceful act, and have little relevance to any incestuous families that come to our attention. These abusive relationships frequently have been going on for years. Several of the children we have worked with have voiced a similar bewilderment: "I don't like what father did, but that was the only time he showed me any affection." Application of these laws sometimes results in the child and family changing their story to protect the offender.

Laws are needed which include strong criminal measures such as imprisonment. Such laws are essential to protect the child from further abuse. So as to not cause further emotional damage for the child, these laws should initially allow for individual and family therapy ordered by the court. Our data show that the incestuous family can be treated successfully. The requirements for this success include a skilled and coordinated investigation; immediate safeguards to separate the incestuous relationships; and court mandated therapy including intensive group, individual and family.

Acknowledgment

Grateful appreciation is extended to Susannah Krehbiel, M.D., child psychiatrist, for her helpful suggestions with this article.

References

1. Sgroi, S.M.: Handbook of Clinical Intervention in Child Sexual Abuse, Lexington, Mass., Lexington Books, p 11, 1982.
2. Zaphiris, A.G. Methods and Skills for Differential Assessment and Treatment in Incest, Sexual Abuse and Sexual Exploitation of Children, Denver, The American Humane Association (AHA), p 3, 1983.
3. A Hidden Epidemic. Sexual Abuse, Newsweek, p 30, May 14, 1984
4. Nakashima, I.I. and Zakus, G.E.: Incest-Review and Clinical Experience, Pediatrics 60:696-670, 1977.
5. Zaphiris, A.G.: Conditioning Continuum Incest; The Family with Two Known Victims, Monograph, Englewood, Col., The American Humane Association, 1978
6. Sgroi, op.cit., p 241.
7. Furniss, T. Mutual Influence and Interlocking Professional-Family Process in Treatment of Child-Sexual Abuse and Incest, Child Abuse and Neglect 7:207, 1983.

• Mr. Arnone, Team Coordinator, Child Protection Team, 301 Broadway, Suite 212, Riviera Beach 33404.

Spasmus nutans occurring with child abuse/neglect

Samuel H. Moorer Jr., M.D.

ABSTRACT: Two cases of child abuse or neglect are reported, failure to thrive and severe and repeated injury. Both had head nodding, head tilt, and asymmetrical nystagmus, features of spasmus nutans. The etiology of spasmus nutans is controversial. It has previously been attributed to a disturbed maternal-child relationship, an etiology which seems likely in the cases presented. Diagnostic investigation of spasmus nutans is known to occasionally yield occult central nervous system tumors. Perhaps the presence of spasmus nutans should also stimulate investigation of family relationships and behaviors in order that child abuse and neglect may be diagnosed and treated.

The Author
SAMUEL H. MOORER JR., M.D.
Dr. Moorer is Medical Director of the Child Protection Team of HRS District II, and is a Pediatrician, Tallahassee.

Spasmus nutans is an unusual, rare, and obscure disease. The triad of head nodding, head tilt, and asymmetrical, often monocular, nystagmus is characteristic if not diagnostic;[1-3] however, instances of acquired transient unequal nystagmus without nodding or head tilt have been accepted in atypical cases.[1,4,5] Spasmus nutans typically begins in infancy and disappears spontaneously in weeks to months. The head bobbing has been noted to appear first with nystagmus following.[6] The nystagmus is most often horizontal and of small amplitude and high frequency ("shimmering"). It may be inconstant, vertical or monocular and has, on occasion, been noted to be greater in the abducting eye on lateral gaze. The head nodding is irregular and may increase when the child inspects an object. A familial occurrence has been noted.

Spasmus nutans has been important to the clinician not only because of its occasional appearance on various certification examinations but also because its typical findings and benign course have been claimed to render unnecessary further diagnostic investigation.[4] However, several recent articles have alerted us to the possibility that more serious conditions may be hidden beneath this rare but benign entity. An unrecognized tumor involving the third ventricular region and optic chiasm may originally present to the clinician as spasmus nutans.[1,7-9] The older literature attributed spasmus nutans to a variety of causes including syphilis, rickets, malnutrition, light deprivation of winter ghettos, poor dentition, trauma and epilepsy.[6] Those more familiar with the topic of this issue of *The Journal* will recognize the association between those conditions and the disordered family lifestyle which so often results in child abuse, neglect, and nonorganic failure to thrive. The

purpose of this paper is to present two illustrative cases and to speculate on the association between spasmus nutans and child abuse/neglect.

Case 1. — A 15-month-old black female was noted by a private physician to have head bobbing without nystagmus and was thought to have spasmus nutans. She had been followed intermittently for a small ventricular septal defect which was hemodynamically insignificant. She had received no immunizations and had multiple impetiginous lesions which were treated with Bicillin. She was referred to a neurologist who confirmed presence of mild to moderate developmental delay but did not note nystagmus or head tilt. She was referred to Developmental Services for an infant stimulation program and was scheduled to return in three months. During that interval appointments for evaluations were not kept, nor did she visit her physician. She arrived in the hospital emergency room at 17 months of age because of fever (103.5 F), refusing food and drooling. During the physical examination the mother incidentally mentioned that the baby's leg was swollen. She denied noticing any abnormal head or eye movements and any history of trauma or injury. Physical examination and immediate x-ray investigation revealed four fractures in varying stages of healing including the distal right humerus (acute), proximal right tibia (four to six weeks' duration), and distal left tibia and fibula (less than three weeks' duration). The left ankle was swollen, tender, and unstable. Head nodding and constant pendular nystagmus of both eyes were quite noticeable. In fact the nystagmus was so marked that funduscopic visualization was almost impossible. During a hospital stay of one month further skeletal x-rays, computerized tomographic scan of the brain, and electroencephalogram were all normal. Iron deficiency anemia was found and treated. Group A beta-hemolytic streptococcus was cultured from an aspirate of the ankle and from the blood. She responded to antibiotic therapy and surgical debridement then and during subsequent hospitalization for removal of bony sequestrum. During the hospital stay the 18-year-old mother was delivered of her third child within a three-year period. During the hospital stay, the patient became quite sociable; developmental status and muscular tone improved; head bobbing and nystagmus decreased significantly, and completely resolved during 18 months subsequent follow-up. The mother's live-in boyfriend stated to the investigating team that he was "trying to teach her to walk." He pled no contest to a charge of aggravated child abuse and received a sentence of ten years. The child and her siblings were placed in foster care and currently are about to be returned to the mother.

Case 2. — A 10-month-old black male was brought to the Child Protection Team by the Single Intake Counselor following referral from the local emergency room for failure to thrive. Although he was born prematurely weighing 2½ lbs after seven month gestation, he had done well. He received nutritional supplementation through the Women, Infants and Children's Program until he was lost to follow-up. There was another sibling 20 months of age. The mother was 18 years old and in the midtrimester of her third pregnancy. She denied any recent illnesses and felt that the boy ate fairly well. He was emaciated; the only subcutaneous fat tissue was a buccal fat pad remnant. His weight was 5.12 kg (far felow the 50th percentile, average weight for a two month old), length was 62.5 cm (far below the 3rd percentile for age, 50th percentile for four months of age), and head circumference was 45 cm (normal for age). A pendular lateral nystagmus was present in both eyes but much greater in the left. There was no head nodding but he was quite weak and hypotonic. He had marked head lag and could barely lift his head when placed prone. He did not remove a handkerchief placed loosely over his face. During a three-week hospitalization, he gained 0.83 kg, became socially more responsive and stronger. The nystagmus gradually disappeared. Work-up revealed no organic disease and included a normal computerized tomographic brain x-ray study. He remains in foster care and an infant stimulation program and continues to improve nutritionally and developmentally.

Discussion • In both cases, spasmus nutans was associated with child abuse or neglect. In the first case, spasmus nutans originally presented as head bobbing with little, if any, nystagmus. This resembles the clinical course originally described by Osterberg.[6] Concurrently there were suggestions of a disordered family situation (neglected immunizations, missed well-baby appointments, single impoverished teenage parent with multiple closely spaced pregnancies, recommendation of infant stimulation program for the child) but no obviously abusive or severely neglectful behavior. During the time the child was lost to follow-up, nystagmus developed and she suffered serious injuries. In the second case, there were also several suggestions that the infant was at risk for abuse or neglect (prematurity, teenage impoverished single parent with multiple pregnancies closely spaced, lack of immunizations). During the time when he too was lost to follow-up, he became seriously malnourished and spasmus nutans developed manifested by asymmetrical nystagmus. He was too weak to accomplish any head bobbing or torticollis. In both cases, spasmus nutans cleared spontaneously and has not recurred. In both cases, no underlying intracranial tumor or defect was found. In the second case, there was no physical abuse but the severe malnutrition responded to the provision of adequate calories and emotional support with a weight gain of one ounce per day for three weeks, confirming the diagnosis of nonorganic failure to thrive secondary to caloric malnutrition and maternal deprivation. Nonorganic causes are the most common etiology for failure to thrive and maternal deprivation is the single most common cause.[10]

The association between growth failure and spasmus nutans was noted in the early literature[2] but lost popularity as a number of other possible causes were suggested. Gresty and Halmagyi[11-13] focused their attention on the abnormal head movements using very specialized research equipment. They believed that head shaking was a learned adaptive behavior which assisted vision in the case of what they called spasmus nutans by interrupting the nystagmus. In other forms of what was presumably congenital nystagmus, the nodding compensated for the nystagmus by assuming the pattern of an inverse wave form and required a suppression of the vestibuloocular reflex. However, this explanation would not fit the atypical cases in which there was

asymmetrical nystagmus without apparent head nodding or the typical cases in which the head nodding apparently preceded the nystagmus.

It has been previously suggested that spasmus nutans is a maladaptive behavioral disorder associated with disturbed maternal-child relationship.[14,15] But this has been disputed in the study of Jayalashmi et al[16] which investigated spasmus nutans cases derived from the Collaborative Study on Cerebral Palsy, Mental Retardation and Other Neurologic and Sensory Disorders of Infancy and Childhood established in 1959. Controls were utilized in which the only stated criterion for selection was a lack of nystagmus at the 12 month examination. They found "disturbed maternal/child relationships" in seven of either 46 or 56 controls. Two were described as over-stimulating, four as under-stimulating and one as tense. Meanwhile, three of the 28 cases of spasmus nutans were believed to be abnormal by the examining psychologist. He noted a flat emotional response in three mothers and one was felt to be very depressed. Interestingly, it was noted that the very depressed mother's child failed to thrive at four months of age but had recovered by one year of age. No further details were available.

Dr. C. Henry Kempe, in the 1979 Jacobi Lecture to the Pediatric Section of the American Medical Association, said "if we, 20 years ago, missed flagrant child battering, we now miss many atypical presentations of child abuse and sexual exploitation."[10] He went on to suggest several atypical presentations of child abuse and neglect but did not include spasmus nutans. Indeed a computer search of the world literature through the past decade turned up no single article cross indexed under both spasmus nutans and child abuse. A recent review of the ocular manifestations of child abuse and neglect do not mention spasmus nutans.[17-19]

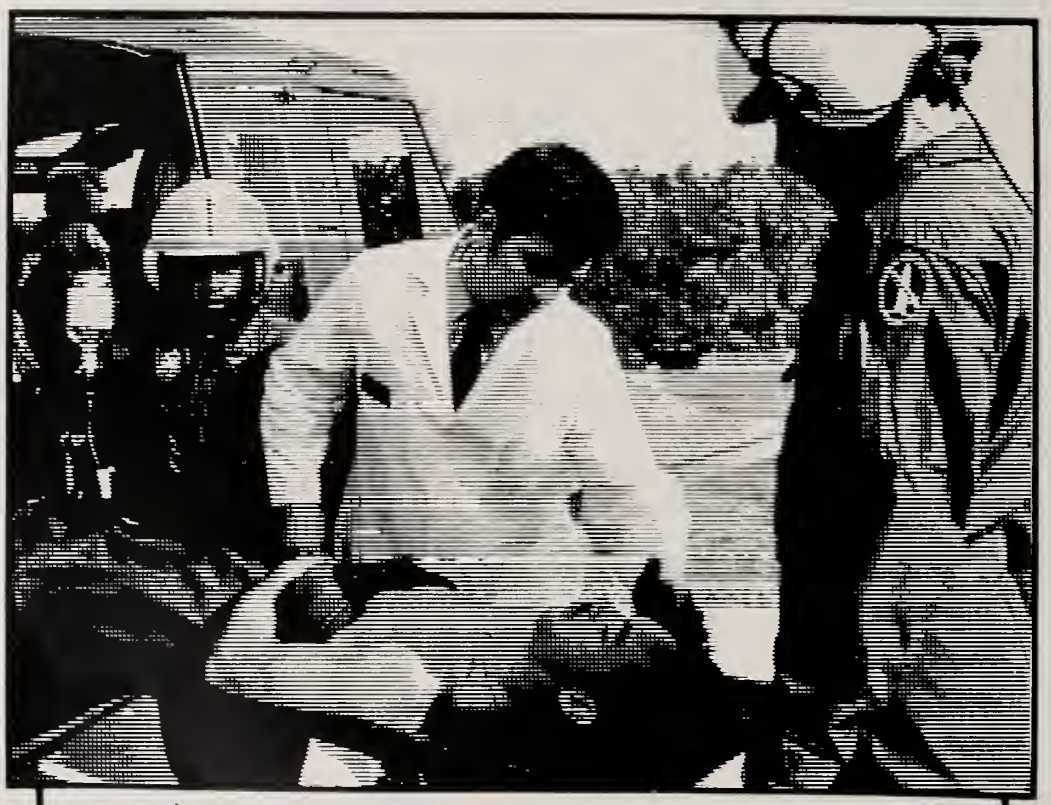
It seems clear that what is termed "spasmus nutans" by the clinician may encompass a variety of disorders with a diversity of causes. When a child with head nodding and nystagmus, particularly asymmetric, is seen by the clinician a diagnosis of spasmus nutans will be entertained. The thorough clinician will then search also for possible occult tumors of the optic chiasm and third ventricular region. Perhaps our two cases will suggest another possibility — that of the disordered family relationship which may lead to the spectrum of child abuse and neglect. Just as additional specialized radiological studies will be employed to rule out tumor, we suggest that specialized behavioral, psychological and social investigations might be employed to rule out the underlying abusive and neglectful behavior. Just as the unrecognized and untreated tumor may progress to more severe consequences if not attended to, the unrecognized abnormal behavior in the untreated disturbed family may progress from simple neglect to potentially criminally abusive assault.

References

1. Antony, J.N : Ourvrier, R.A., and Wise, G.: Spasmus Nutans: Mistaken Identity, Arch. Neurol. 37:373-375, 1980.
2. Thomson, J.: Note on Peculiar Nystagmus of Spasmus Nutans in Infants, Br. Med. J. 1:763, 1901.
3. Walsh, F.B. and Hoyt, W.F.: Clinical Neuro-Ophthalmology, ed. 3, Baltimore, The Williams & Wilkins Co., vol. 1, pp. 274-277, 1969.
4. Keltner, J.L.: Neuro-Ophthalmology, Pediat. Ann. 12:597, 1983.
5. Katzman, B.; Lu, L.W., and Tiwari, R.P.: Spasmus Nutans in Identical Twins, Ann. Ophth. 13:1193-1195, 1981.
6. Osterberg, G.: On Spasmus Nutans, Acta Ophth. 15:457-459, 1937.
7. Koenig, S.B.; Naidich, T.P., and Zaparackas, Z.: Optic Glioma Masquerading as Spasmus Nutans, J. Pediat. Ophth. 19:20-24, 1982.
8. Schulman, J.A.; Shults, W.T., and Jones, J.M. Jr.: Monocular Vertical Nystagmus as Initial Sign of Chiasmal Glioma, Am. J. Ophth. 87:87-90, 1979.
9. Lavery, M.A.; O'Neill, J.F.; Chu, F.C., and Martyn, L.J.: Acquired Nystagmus in Early Childhood; Presenting Sign of Intracranial Tumor, Ophthalmology 91:425-435, 1984
10. Kempe, C.H.: Child Abuse — Pediatrician's Role in Child Advocacy and Preventive Pediatrics, Am. J. Dis. Child 132:255-260, 1978.
11. Gresty, M.A. and Halmagyi, G.M.: Abnormal Head Movements, J. Neurol. Neurosurg. Psychiat. 42:705-714, 1979.
12. Gresty, M.A. and Ell, J.J.: Spasmus Nutans or Congenital Nystagmus? Classification According to Objective Criteria, Br. J. Ophth. 65:510-511, 1981.
13. Gresty, M.A. and Halmagyi, G.M.: Head Nodding Associated with Idiopathic Childhood Nystagmus, Ann. N.E. Acad. Sci. 374:614-618, 1981.
14. Greenberg, N.H.: Origins of Head-Rolling (Spasmus Nutans) During Early Infancy, Psychosom. Med. 26:162, 1964.
15. Fineman, J.A.B.; Kunibolm, P., and Seridan, S.: Spasmus Nutans: Syndrome of Auto-Arousal, J. Am. Acad. Child Psychiat. 10:136, 1971
16. Jayalashmi, P.: Scott, T.F.McN.; Tucker, S.H., and Schaffer, D.B.: Infantile Nystagmus: Prospective Study of Spasmus Nutans, Congenital Nystagmus, and Unclassified Nystagmus of Infancy, J. Pediat. 77:177-187, 1970.
17. Harley, R.D.: Ocular Manifestations of Child Abuse, J. Pediat. Ophth. 17:5-13, 1980.
18. Gammon, J.A.: Ophthalmic Manifestations of Child Abuse. In Child Abuse and Neglect, Ellerstein, N.S., ed., John Wiley & Sons, New York, 1981.
19. Nelson, L.B. and Parlato, C.J.: Systemic and Ophthalmic Manifestations of Child Abuse, Clin. Ophth. #5:1-11, 1984, Chapter 44.

● Dr. Moorer, Team Medical Director, Child Protection Team, 2420 East Plaza Drive, Tallahassee 32308.

PHYSICIANS, A WEEKEND WITH THE RESERVE ISN'T JUST ANOTHER DAY AT THE OFFICE.



It's not just different in the Army Reserve, there are opportunities to explore other phases of medicine, to add knowledge, and to develop important administrative skills. There are enough different needs to fill right in your local Army Reserve unit to make a weekend a month exciting and rewarding.

Explore the possibilities. Call our officer counselor:

(North Florida)
CPT WINOKUR, MSC
(305) 896-4930/4793 COLLECT
USAR AMEDD PROCUREMENT
3101 MAGUIRE BLVD., SUITE 166
ORLANDO, FL 32803

(South Florida)
CPT WALTER DAVIS, MSC
(305) 667-5600/5609
USAR AMEDD PROCUREMENT
SUITE 207, 5900 S.W. 73RD STREET
MIAMI, FL 33143

ARMY RESERVE. BE ALL YOU CAN BE.

Getting ahead in medicine is an uphill climb.

Unless you have a BellSouth Mobility car phone.

Turn drive time into prep time. This year, our car phones are going to be one of the most popular ways for doctors to control high blood pressure—their own.

Because BellSouth Mobility cellular car phones allow doctors to stay in constant touch. To plan ahead. And to have the frustration of the pay-phone routine painlessly removed by allowing you to give your service an immediate buzz when you get beeped on the road.

Advanced service network. Ours is the most advanced phone system on wheels. It's just as easy to use as your office phone. And it's the only one with a state-of-the-art service network behind it. Making sure that your car phone—and your patience—are state-of-the-art. Now, and down the road.

Call BellSouth Mobility toll-free at 1-800-351-3355. And from there, it's all downhill.

BellSouth Mobility

All you need to know about mobile communications.℠

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

TWELFTH ANNUAL REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

July 28 - August 10, 1985

SHERATON BAL HARBOUR HOTEL — BAL HARBOUR FLORIDA

Director: J. Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for *certification in internal medicine.* It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed materials with references and self-assessment questionnaires will be provided to all registrants. Pictorial quizzes, patient management problems, videotape symposiums and audiovisual teaching aids will be offered throughout the meeting. This course will end 30 days prior to the certification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

A faculty especially selected for its expertise in review courses will present the following topics:

Week I	**Week II**
Infectious Diseases	Slide Review and/or Videotape Session
Immunology — Allergy	Cardiology
Genetics — Oncology — Nuclear Medicine	
Endocrinology	Pulmonary
Gastroenterology — Hepatology	Critical Care — Hypertension
Ophthalmology — Pharmacology — Toxicology — Dermatology — Laboratory	Acid-Base — Renal
	Rheumatology
Neurology — Psychiatry — Radiology	Hematology

HIGHLIGHTS

- **Audio-Visual Aids**
- **Pictorial Quizzes**
- **Self-Assessment Sessions**
- **Patient Management Problems**
- **88 hours of AMA Category I Credit**
- **Printed Materials**
- **Self-Assessment Questionnaires**
- **Meet the Faculty Sessions**
- **Video Tape Symposiums**

Registration: Entire Course (July 28-August 10) $750* (Before May 31) $800 (After May 31)
Week I (July 28-August 3) $550
Week II (August 4-10) $550

Enrollment must be limited because of extensive faculty / registrant interaction.

Priority will be given to those registering for the entire course.

For registration and information write to: Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760, Miami, Florida 33101

**Includes tuition, printed materials, self-assessment questionnaires, use of audiovisual aids, library loan of TV tapes, cassette tapes and set of slides.*

General practice in rural Florida: case study of an anomaly

David P. Adams

After the turn of the century, a definite trend emerged toward both urbanization and specialization of the American medical profession. Medical schools were undergoing massive restructuring of curricula in response to the scathing Flexner Report of 1910, a survey which stood as a sad commentary upon the training of American physicians. As medical colleges restructured their programs under the impetus of reform, many schools — deemed "utterly wretched" by Abraham Flexner — either merged with other institutions, revised their curricula, or closed their doors altogether.[1]

Those physicians who graduated from medical schools which survived the Flexner Report by adopting both curriculum and entrance requirements along the Hopkins model generally opted for urban, if not specialized, practice. Not only did larger cities offer wider opportunities for specialization, they also provided greater financial security and professional association. As Table 1 indicates, fewer medical school graduates entered private practice in rural areas, choosing instead the more urbanized and lucrative sections of the country.[2]

The Author
DAVID P. ADAMS
Mr. Adams is a graduate student and a resource faculty in the Medical Humanities Programs, Department of Community Health and Family Medicine, University of Florida, Gainesville.

Despite this trend away from general medicine and smaller population bases, some apparently well-trained physicians did choose to begin practice in rural areas, plagued by poor secondary roads, that were miles from the nearest hospital. One was James H. Kirby, who practiced in Orange, Florida from 1928 until his death in 1974.[3]

Education and training • A graduate of Georgia Medical College, class of 1927, Dr. Kirby — unlike other physicians within his county who served as the sole health care provider for their communities — could boast of having a degree from an accredited medical school. None of his colleagues in similar practice in the county in 1931 could make such a claim. Those who had graduated from accredited medical colleges (Tulane University School of Medicine and Jefferson Medical College of Philadelphia) had done so long before these schools received either Flexner's or the AMA's accreditation. The Jefferson graduate received his degree in 1878.[4]

Indeed few rural areas served by only one physician were as well cared for as Orange. The combination of Dr. Kirby's recent training and youth (he was only 25 when he entered practice) suggests a high level of medical knowledge as well as good health in general when compared with the ages and credentials of other practitioners in the county. By 1931 only 7% of Florida's rural practitioners had graduated from medical school within the past ten years (Table 2).[5]

As "physician and surgeon," James Kirby entered practice in quite a different setting from that of his internship, the Duval County Hospital at Jacksonville. Kirby's community would not have its own clinic, provided by the physician himself, until

Table 1. — Medical College Graduates in Privatre Practice by Size of Community of Practice, 1930, 1935, 1940, and 1945 Classes Throughout the United States.

Size of Community of Practice	Year of Graduation 1930	1935	1940	1945	Percent Change (1930-1954)
Total	2,666	2,640	2,742	3,178	+19.2
500,000 and over	768	675	663	626	+72.0
100,000-499,999	429	549	589	738	+37.3
50,000-99,999	181	255	299	340	+87.8
25,000-49,999	151	246	328	356	+135.8
5,000-25,999	445	483	480	675	+51.7
Under 4,999	682	401	361	438	−35.8
Unknown	10	31	22	5	

Source: H.G. Weiskotten and Marion E. Altenderfer, Trends in Medical Practice, Chicago: Association of Medical Colleges, 1956, p. 23.

the late 1940s. As he discovered upon his first visit to Orange, transportation was very often an ordeal on even the best roadways — his Model T overturned as he was entering town for the first time.[6]

Problems and practice • Faced with meager facilities, not least when making a call to a home lacking electricity, running water or other conveniences, Kirby often "worked by the seat of his pants."

Table 2. — Decade of Graduation from Medical School for Physicians Practicing as Sole Health Care Provider for their Community in Florida in 1931.

Decade of Graduation	Number
1870-1880	5
1881-1890	11
1891-1900	24
1901-1910	37
1911-1920	30
1921-1930	8
Total	115

Source: American Medical Directory, 12th ed., 1931, pp. 405-417.

During the Depression years especially, many patients had no automobile; Dr. Kirby often treated them in their homes. As his wife noted, he "made house calls all the time."[7]

His office schedule was no less hectic and an average day consisted of seeing the first patient at 10:00 a.m., continuing into the afternoon, and then leaving for rounds in a hospital approximately a 45 minute drive south of Orange. All too often he would return to find an emergency case awaiting attention.[8]

With the exception of very serious cases transported to this hospital, Dr. Kirby conducted much of his practice from the first floor of his home for nearly 20 years. Only then did he construct a separate facility. His original office was composed of eight examining rooms (with several specified as "colored") and three waiting rooms, two for "white" and one for "colored." Surgeries, on the other hand, were scheduled weekly so that he might obtain assistance from colleagues in a nearby town of approximately 7,000 people. According to his wife, Dr. Kirby's operating room was well equipped, and he prided himself on never having lost a patient in surgery.[9]

Dr. Kirby could probably not have chosen a poorer time to enter medical practice, particularly in such a rural area. Aside from the devastating effect the Depression had upon rural populations, general practitioners did not fare well either during the 1930s. Fees for many of them became nonexistent; in Dr. Kirby's case, he was often paid vegetables or hams. His wife and son recall that he never insisted upon patients paying — and some did not.[10]

As one 1933 study indicated, families with an income of less than $1,200 and living in rural areas incurred "very little or no expense for medical care." The report added, however:

> This does not indicate that these families were all in a state of abundant health. Many of them had so little money that a physician was not called; few had any dental care; and many had more care than their charges indicate because part of the medical service they received was free.[11]

Recreational time for Dr. Kirby was nearly as scarce as financial gain from his practice. Seldom was his time his own and even a fishing trip with his son was often somewhat less than private. Kirby's rapport with his patients usually meant that he could not go anywhere in Orange unnoticed by at least one of them. Whether walking down the street or quietly fishing with his son, Dr. Kirby's services were in constant demand. His son recalled a fishing outing: as the two were sitting in their boat, a patient pulled alongside to relate an illness.[12]

Day trips out of town were hardly any different. During the fall, Dr. Kirby would occasionally take his family to a nearby town for an afternoon of college football. He was assigned a parking space near the stadium in the event of an emergency. Such incidents were not uncommon and, paged over the public address system, he and his family would leave the unfinished game so that he might attend to the patient.[13]

Late night emergencies proved arduous, if not dangerous at times. Most common were childbirth cases and, on occasion, auto accidents "up the highway." In general, Dr. Kirby attended only the births of white babies, leaving the care of black mothers to local midwives. When complications arose, however, he was often summoned unexpectedly to the bedside of one of his black patients. Poor roads and inadequately fenced pastures made these calls quite dangerous. Once returning from a late night call he accidently struck a cow that had wandered onto the roadway.[14]

Dr. Kirby used a wide variety of drugs. Unlike an older colleague in a neighboring county who was a 1909 graduate of the Atlanta College of Physicians and Surgeons, he kept current on newer pharmaceutical developments. When one compares the prescription files of Dr. Kirby with those of Dr. Smith in Elton, this becomes strikingly clear, particularly in regard to the "wonder drugs" which appeared in the late 1930s and throughout the 1940s. Although Dr. Smith began prescribing sulfanilamide at approximately the same time as Dr. Kirby, the former's prescription files indicate that he never yielded to newer medications (especially penicillin) to any great degree. A review of his prescriptions shows that when he did use newer forms of the sulfas, he consistently misspelled their names. Dr. Kirby, on the other hand, shifted to increased prescription of penicillin as it became more widely available. Even if Dr. Smith had not been keeping abreast of medical advances through JAMA or other journals, he should have been aware of penicillin as a result of the coverage through the popular press.[15]

The initial years of Dr. Kirby's practice forced him to compound and dispense his own drugs; Orange had no pharmacy until the early 1930s. When one considers the many pharmacies that did not survive the Depression years, Dr. Kirby was fortunate to have had the services of a professional pharmacist at all. Without the convenience of brand name drugs, he generally wrote prescriptions that required tedious compounding and measurement.[16]

Despite Dr. Kirby's isolation in Orange, his prescribing practices do not appear very different from those of an urban practitioner. As a 1935 American Pharmaceutical Association survey indicated, aspirin and sodium bromide were numbers two and five respectively as the most commonly prescribed single ingredients. Both substances appear throughout Kirby's prescription files and were often prescribed as a compound. Indeed, sodium bromide appears in nearly 20% of a random sample of his prescriptions. Alone, sodium bromide was used as a sedative; in combination with aspirin Dr. Kirby often prescribed it every four hours "when needed for restlessness or to reduce fever."[17]

Quinine, despite a serious malaria problem in Orange during the middle 1930s, accounted for only around 8% of Dr. Kirby's prescriptions. Most of these appeared during the peak malaria years and then fell of sharply as the disease abated. Although one physician, a graduate of the University of Virginia School of Medicine in 1936, lamented that quinine had been a standard cold remedy for decades, he had been taught to use the drug only for cases of malaria.[18] Such a specific use characterized Dr. Kirby's practice as well. In fact, his prescriptions for quinine exhibit an almost textbook quality; judging from the admonitions of Cecil's Textbook of Medicine (1930 edition) Dr. Kirby's dosages were letter perfect.[19]

By the late 1930s, Marshall Taylor and his associates reported that quinine could cause hearing impairment and appear in the blood specimens of newborns as well. If, as Dr. Kirby's family pointed out, the Orange physician was eager to keep current on the latest medical developments, he probably knew of Taylor's work firsthand; he was an active participant in both local and state medical societies.[20]

Anomaly of modern medicine • Dr. Kirby was quickly becoming an anomaly of modern medicine by 1930. General practice had become far less attractive to young physicians and rural areas failed to attract new practitioners to take the places of those who were dying off. Although Dr. Kirby was 25 when

he began practice in Orange, his colleagues, who were also the sole health care providers in other communities around the county, averaged nearly 60 years of of age. As Table 3 shows, however, the mean age of physicians in urban areas around the state was considerably lower. In a nearby community of over 7,000, the mean age of all physicians in 1931 was only around 48.[21]

The older practitioners in rural areas were not being replaced. As was the case with Orange, the community physician simply practiced until incapacitated by illness or death. Dr. Kirby himself replaced the recently deceased town doctor. During this era "The Physician's Business," a manual dealing with the practical economics of medical practice, suggested that rural medicine could prove a very positive experience:

> The inducements offered are that expenses are at a minimum, and collections better than in the city, where the population is do largely shifting. If these advantages outweigh the allure of the city in the eyes of the young doctor, he will do well to equip himself with a good road map, listing towns and their populations.

Table 3. — Mean Age of Physicians in Florida Communities Over 10,000 persons, 1931.

City	Population	Mean Age
Sanford	10,100	46
Tallahassee	10,700	46
Key West	12,831	49
Daytona Beach	16,598	48
Lakeland	18,554	47
West Palm Beach	26,610	53
Orlando	27,330	42
Pensacola	31,579	45
St. Petersburg	40,425	52
Tampa	101,161	51
Miami	110,637	43
Jacksonville	129,549	48

Source: American Medical Directory, 12th ed., 1931, pp. 405-417.

With a little luck, one might even find a town that had been "left doctorless."[22]

Since Dr. Kirby's death in 1974, Orange has been left essentially without medical care of its own. When a physician's services are needed the individuals are forced to travel to a nearby community, usually a round trip of at least an hour. Those few physicians who have attempted to practice in Orange since 1974 have not remained for an extended period. Today, although the pharmacy serves the community, local medical care is available only two days a week.

One can only speculate about Orange's relative lack of local health care. Certainly, general practice in such a community, as Dr. Kirby's experiences indicate, would often prove demanding and would leave little room for private life. Financial concerns might also be a major factor. The expense of medical school (and possible loan debts upon graduation) might well entice a graduate to seek the most lucrative practice available. Orange would hardly be an optimal setting for great financial gain. One wonders, however, if the predicted glut of physicians will induce some to seek locations in the less competitive medical markets rather than major urban centers.

References

1. Stevens, R.: American Medicine and the Public Interest, New Haven; Yale University Press, 1971, pp. 67-68; see also, Starr, P.: Social Transformation of American Medicine, New York, Basic Books, 1982, pp. 118-123.
2. Weiskotten, H.G., and Altenderfer, M.E.: Trends in Medical Practice, Association of American Medical Colleges; Chicago, 1956, p. 23.
3. James H. Kirby, M.D., and Orange, Florida are pseudonyms for an actual physician and community. Their true identities have been omitted in order to protect the anonymity of family members and the community upon which this study is based. "Rural" is defined as communities with less that 1,000 persons and "sole health care provider" as the only physician listed for a particularly rural community, based on the listing in the American Medical Directory, 12th ed., 1931.
4. American Medical Directory, 12th ed., American Medical Association, 1931, pp. 40S-417.
5. Ibid.
6. The following description of Dr. Kirby's practice is taken from a personal interview with his family, July 2, 1984.
7. Ibid.
8. Ibid.
9. Ibid.
10. Ibid; Stevens, American Medicine and the Public Interest, pp. 176-177.
11. Reed, L.D.: Ability to Pay for Medical Care, Publications of the Committee on the Costs of Medical Care, No. 25, Chicago. University of Chicago Press, 1933, pp. 66-67.
12. Kirby Family, personal interview.
13. Ibid.
14. Ibid.
15. Dr. Smith and Elton, are pseudonyms for an actual physician and Florida community in which he practiced. Their true identities have been omitted in order to protect the anonymity of the family members and community upon which this study is based. The data on the prescribing practices of both Dr. Smith and Dr. Kirby are based upon the prescription files from the "Orange" and "Elton" pharmacies. The former are in the personal files of David P. Adams, Department of History, University of Florida, Gainesville; the latter are in the possession of Alvin Hendrix. The author wishes to thank Mr. Hendrix and Grady Smith for their kind assistance on obtaining the prescription files of Drs. Kirby and Smith. For a recent treatment of penicillin's image in popular press, see David P. Adams, "The Penicillin Mystique and the Popular Press (1935-1950)," Pharmacy in History 26 (1984), pp. 134-141. See also, David P. Adams, "Penicillin and American Civilian Compliance: 1943-1945," unpublished seminar paper, Washington University in St. Louis, 1982.
16. Kirby family, personal interview; prescription files of "Orange" Pharmacy. The conclusions concerning Dr. Kirby's prescribing practices are based on a random sample of 370 prescriptions written by him between 1933 and 1947. See also Lillian H. Bowen, N.A.B.P. Statistical Survey: National Survey and Analysis by State, Chicago: National Association of Boards of Pharmacy, 1936.

17. Delgado, F.A.: Professional Pharmacy: An Analysis of Prescription Department Activities, 2nd ed., Washington, D.C., American Pharmaceutical Association, 1935, pp. 65-69; prescription number 12584, filled September 18, 1936, "Orange" pharmacy. The author would like to acknowledge the assistance of Herbert Lewitt, pharmacist, Panama Drugs, Jacksonville, Fl., for his help in analyzing the prescriptions in the "Orange" files.
18. "Orange" files; personal interview with Frederick Bowen, M.D., Jacksonville, April 30, 1984.
19. Cecil, R.L.: A Textbook of Medicine, 2nd ed, Philadelphia: W.B. Saunders, 1930, pp. 395-396
20. Kirby family, personal interview. For Taylor's early work, see especially, H. Marshall Taylor, "Impaired Hearing from Certain Drugs and Chemical Poisons," J. Fla. M. A., January 1938, 377-383; H. Marshall Taylor, Lucien Y. Dyrenforth, and Cash B. Pollard, "Absorption of Quinine into the Cerebrospinal Fluid of the Fetus Utero, "J. Fla. M. A., April 1941, 487-491. The latter also appears in Ann. Oto. Rhin. Laryn., December 1941, 1030-1037.
21. American Medical Directory, 12th ed., 1931, pp. 405-417.
22. Wolf, G.D.: Physician's Business: Practical and Economic Aspects of Medicine, Philadelphia, J.B. Lippincott, 1938, pp. 30-31.

Acknowledgments

The author would like to thank Dr. Lee Crandall for his helpful comments and the Department of Community Health and Family Medicine, University of Florida College of Medicine, for its assistance in preparation of the manuscript.

• Mr. Adams, University of Florida, Department of History, 4131 GPA, Gainesville 32611.

Academic radiology: can it survive?

Juan V. Fayos, M.D.

We are entering an era of intense competition in medical care. It is difficult to estimate the impact of this development, particularly for medical schools and teaching institutions that care for a large segment of the poor or near poor population. It is even more difficult to estimate the impact that such competition will have on the separate departments that are part of such large institutions.

Traditionally, medical school revenues have come from a broad spectrum of sources: tuition, state and federal support, private philanthropy, patient care fees and research grant support, generally from the Federal Government. In recent years, however, this broad support to educational institutions has changed substantially.[1,2] Cessation of capitation grants, decreases in both philanthropy and research support from all sources, including the Federal Government, have had effects on medical school budgets. To make matters worse, all these changes have occurred at a time of increasing costs.

The high increase in medical cost has resulted in legislative changes aimed at reducing payments. The most recent one will reimburse hospitals with payments based on the average cost of hospitalization in nine regions of the country: the Diagnostic Related Groups (DRG) for Medicare patients. This presumably will nurture efficiency and competition, but might have an adverse effect on teaching institutions. In addition, the development of other prospective payment plans, competitive bidding for physician and hospital services, etc. could have also unforseeable consequences for academic institutions.

A medical school is obviously a complex institution with a variety of goals. Its faculty not only has to deliver a sound theoretical basis to students, but also has to provide patients for its students to teach them the "art and science" of medicine. In large schools, it becomes imperative that a sufficient number of patients be available to fulfill this function. For example, the University of Miami (UM), as well as other medical schools, has developed affiliations with other hospitals. The UM's main affiliation is with Jackson Memorial Hospital (JMH), a hospital partially supported by Dade County to care also for the indigent patient. This association permits the medical school to have a large patient body that satisfies its educational goal. The faculty is responsible at JMH for teaching residents in the hospital program, supervising the care rendered to patients, and administrating the medical services of the hospital. As a consequence of this association, high quality medical services, from primary to tertiary care, are given to the paying as well as to the nonpaying patient.

In an effort to fulfill their education mission while at the same time creating a broader financial base, most medical schools, including the University of Miami, have developed medical service plans.[3] These plans collect the professional component of the medical cost, most often reimbursed by a third-party on a fee-for-service basis. Consequently, the medical faculty is increasingly competing against

The Author
Juan V. Fayos, M.D.
Dr. Fayos is Professor of Radiology, Director, Division of Radiation Therapy, University of Miami School of Medicine, Jackson Memorial Hospital, Miami.

the community physicians for the paying patient in an effort to increase revenues.

To determine the current viability and future expectations of a large academic department, a financial analysis of the Department of Radiology at the University of Miami School of Medicine was conducted. Revenues, expenditures and constraints in the delivery of radiological services were analyzed.

Financial Status of Radiology — Revenues • In the fiscal year 1981-1982, the main revenues for our department came from patients' services (67%), reflecting the increasing dependence of this source of revenue upon the financial survival of the department. Next came fixed support from Jackson Memorial Hospital (26%), and the UM School of Medicine (6.6%). Gifts and research contracts from the Federal Government contributed a meager 0.4%. Of a total gross revenue of $7.9 million generated in fiscal year 1981-1982, one third, or $2.6 million, was actually collected. This is due to the large number of indigent, refugees, and near poor people who received radiological services but were unable to pay for them. In the fiscal year 1981-1982, the department did not receive any payments for almost $2.5 million of services rendered to the indigent/refugee population of Dade County. Poor or near-poor patients unable to qualify for any entitlement programs were not included in the above figure.

Medicare contributed 35.6% of all net revenues for the fiscal year 1981-1982 and yet they constituted 10.6% of gross revenues. These figures display the paramount importance of this program in the fiscal stability of our academic department. Medicaid patients generated 20.6% of our gross revenue ($1.6 thousand) for the year 1981-1982 and produced 17.3% of the net income ($0.46 million). In short, payments from Medicaid were 28.5 cents to the dollar for the fiscal year 1981-1982, a substantial discount and one of the reasons why many private practitioners do not accept this type of patient. Even though the amounts paid by Medicaid are heavily discounted, the importance of the program on the financial solidity of a department such as ours cannot be underestimated. If Medicaid did not exist, this revenue would have to be written off completely as are the gross revenues from indigent and refugee patients.

Expenditures • The largest expenditure is for faculty salaries and fringe benefits, which constituted 78.1% of all expenditures ($2.8 million) in fiscal year 1980-1981. Salaries paid to the faculty averaged about $75,000 a year. They are below the 50 percentile of the average salaries paid to physicians in academic medicine throughout the country and below those paid in the private sector. The median net salary for private practice radiologists who work primarily in hospitals is $127,310.[4]

Administrative and billing expenses were the second largest expenditure, 11.6% ($0.5 million). Next came a medical school "tax" with 7.2% of expenses or $0.3 million. The department contribution to the medical school was higher than the contribution of the medical school to Radiology. In effect Radiology financially subsidizes the medical school and absorbs the cost of teaching students and residents. No significant allocation was given to clinical research or purchase of equipment for research purposes, perhaps the gravest deficiency of our department.

Discussion • As a result of increases in expenditures and the low collection ratio of our department (Diagnostic and Therapeutic Radiology and Nuclear Medicine) due to the large burden of nonpaying patients, an annual deficit has occurred consistently since fiscal year 1978, in spite of revenue shifting from one division to the other.

If academic departments cannot entirely subsidize the medical care of the poor or near poor while fulfilling their primary functions of teaching and research because of financial constrains, what are the options available?

The most common action taken to solve budget deficits is to increase the price of each procedure. We have followed this dictum and have increased our prices steadily. In fiscal year 1981-1982, the increase was 17% on the average price of each procedure. This increase has permitted certain fiscal solvency, but it has shifted significantly costs to the paying patients in an effort to subsidize our nonpaying ones. However, in view of increased competition and federal government actions to arrest price increases, it is unlikely that this mechanism will be maintained for long. The prices for services rendered by UM will be so out of line with competing radiological services that a further drop in the number of paying patients will occur as we price ourselves out of the radiological market.

An action to correct financial deficits is to cut down expenditures. In Radiology, the largest expenditure is the payment of faculty salaries and fringe benefits. Consequently, elimination of the number of physicians necessary to balance the budget would appear to offer a solution, provided that a commensurate reduction in the services to those patients who do not pay were carried out. While this solution is feasible for certain industries, such as automobile, manufacturing, etc., it is not feasible for public health institutions, which have to provide care for the very poor who have no access to other facilities. Therefore, reducing the number of physicians and

their corresponding services is not a solution, but would add to the problem of providing medical services to the poor.

Another device to reduce cost is labor substitution from an expensive producer to a less expensive one. It is possible that certain radiological procedures could be done by individuals less qualified than a radiologist. For example, an x-ray technologist or a medical student could read, unsupervised, all chest x-rays on indigent patients or a nurse could administer radiotherapy to certain patients with malignant tumors. These are options that, although feasible, are not bound to occur. They will be equivalent to the creation of a multi-level system of medical care, one for the poor and a better one for the paying patient, a condition that society, government, and physicians reject at the present time. Commitment to medical care of equal quality for all is presently an important societal goal.

Since nonpaying patients pose the greatest financial problems to institutions such as ours, one obvious solution would be to support legislation inducive to a national health insurance system. If everyone paid for services rendered, be it on a fee-for-service or prospective basis, the distribution of the nonpaying patients in a community to a single health facility would disappear. However, the present political climate in Congress is contrary to this development due to the expected high cost of the program.

It is evident that academic medicine cannot continue to cover costs from teaching and research activities out of patients' revenues as in the past and particularly in those institutions facing a high load of nonpaying patients as in our case.

Consequently, in order to fulfill the objectives of academic institutions towards education (graduate and post-graduate), research and service to patients, the present financial arrangement must be altered.

One solution would be to give grants for clinical research and teaching to medical schools and teaching hospitals from the federal or state governments financed out of general revenues. The likelihood of this solution is poor indeed, particularly in this era of tight budgets.

Another solution would be to allocate a portion of the health care bill contributed by the government (Medicare, Medicaid), third party carriers, etc. to a special fund for teaching, education and research. Different schemes to support teaching and clinical research have been suggested, including the creation of a national fund for teaching hospitals (5). However, such a national fund would be burdensome to administer and subjected to a great deal of political pressures which may lead to a larger distribution of benefits to certain regions or institutions at the expense of others.

Conversely, a state fund might be the proper mechanism for a teaching and research fund for medical use. Each state could tax health insurance carriers and other health providers to generate the necessary funds to support as much research and teaching as each state would desire. In this fashion, all of the participants in the health industry would contribute to education and clinical research, rather than the few institutions that at present are doing it on a cost-shifting basis.

If institutions such as ours were to be paid for teaching and clinical research from dedicated funds such as that described above, they will be in better position to compete with other health provider organizations while delivering medical care of excellent quality to a segment of the poor in our society. However, if no substantial financial changes are made in the way we finance our teaching institutions, they are certainly headed towards rough times with unavoidable decay of their missions.

Summary ●The main problems facing teaching institutions affiliated with hospitals that accept a large load of indigent patients are a) the delivery of medical services not being paid for, and b) the lack of appropriate financial support for teaching and clinical research functions.

As we enter an uncertain stage in the financing of medical care with a movement towards pluralistic concepts of payment, including HMO's, prospective payments, fee-for-service, etc., academic institutions and their corresponding departments might suffer substantially in their mission unless changes in financing their different activities are found. One solution to problems in academic medicine might lie in the creation of a state fund earmarked for teaching and clinical research financed by the health insurance industry and government. This fund will support teaching and clinical research, thus freeing academic institutions and the paying patients of the enormous burden of cross-subsidizing education and research out of clinical service activities. If funds earmarked for teaching and research were to come separately to academic institutions, they should be able to compete in an open market for patients' services on an equal basis, while still providing a large amount of care for the nonpaying patient.

References

1. Cluff, L.E.: Medical Schools, Clinical Faculty, and Community Physicians. Special Communications — JAMA, 1982, 247:200-202.
2. Inglehart, J.K.: Shrinking Federal Support Brings New Era to Education in the Health Professions. Health Policy Report — The New England Journal of Medicine, 1981; 305:1027-1032.
3. Schmidt, C.W., Jr.; Zieve, P.D.; D'Lugoff, B.C.: A Practice Plan in a Municipal Teaching Hospital; A Model for the Funding of Clinical Faculty. Special Article — The New England Journal of Medicine, 1981; 304:263-269.
4. Holoweiko, M.: Those Hospital Specialties: Alive and Very Healthy. Medical Economics, March 7, 1983,pp. 148-171.

5. Colloton, J.W.: Competition: The Threat to Teaching Hospitals. In Financing Health Care: Competition versus Regulation. The Papers and Proceedings of the Sixth Private Sector Conference. Edited by Duncan Yaggy, Ph.D. and William G. Anlyan, M.D. Ballinger Publishing Co., Cambridge, Mass., 1982, pp. 131-228.

● Dr. Fayos, University of Miami School of Medicine, Division of Radiation Therapy (D-31), P.O. Box 016960, Miami 33101.

AN AVIS WIZARD NUMBER. FOR PEOPLE WHO HATE TO WAIT.

It means speedy service, along with special flat rates, for association members.

Avis knows it's frustrating to have to wait for your rental car. That's why we invented the Wizard Number. Once your renting information is on file in our Wizard of Avis computer, you'll be able to reserve an Avis car quickly — at your special association rate.

What's more, with an advance reservation, an Avis Wizard Number entitles you to time-saving services like Avis Express too. At many U.S. airports, it lets you bypass the rental lines and go straight from your plane to the Avis Express facility, where your rental agreement and your car will be waiting. Ask for Avis Express when you reserve your car. All you need is an Avis Wizard Number. (If you don't have one, just complete the application below and mail it in.)

Avis also has many other special services for association members who hate to wait. Ask about them when you call Avis toll free to reserve your car:

1-800-331-1212

THE FLORIDA MEDICAL ASSOCIATION, INC. 1874

Your Avis AWD Number:
A/A 616900

AVIS WIZARD NUMBER APPLICATION

Complete and mail to: AVIS, P.O. Box 201, Garden City, NY 11530 Attn: AVIS WIZARD NUMBER DEPARTMENT

F.I. M.I. LAST NAME

MAILING STREET ADDRESS

CITY STATE ZIP

COMPANY NAME

ADDRESS ABOVE IS (Check one)
☐ 1. HOME ADDRESS ☐ 2. COMPANY ADDRESS

DRIVER'S LICENSE # (Include all letters and numbers)

STATE OF ISSUE AVIS AWD # A/A 616900

CHARGE CARD YOU PREFER TO USE:
(Please select only one)
☐ 3. AIR TRAVEL ☐ 4. AMERICAN EXPRESS
☐ 5. DINERS CLUB ☐ 6. VISA
☐ 7. MASTERCARD ☐ 8. CARTE BLANCHE

CARD NUMBER
(Include all letters and numbers)

If you list a credit card but prefer to pay in cash, please check this box: ☐

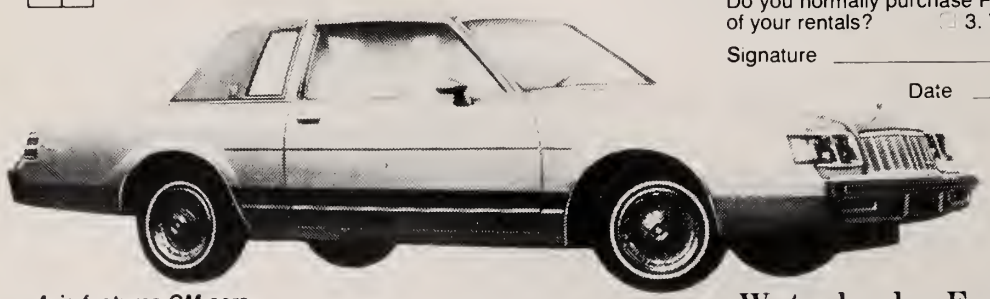
CAR GROUP PREFERENCE: (Please check one box)
☐ 12. COMPACT (Buick Skyhawk or similar)
☐ 13. INTERMEDIATE (Oldsmobile Omega or similar)
☐ 14. FULL SIZE 2-DR (Buick Regal or similar)
☐ 15. FULL SIZE 4-DR (Oldsmobile Cutlass Ciera or similar)

Do you normally purchase the Collision Damage Waiver as part of your rentals? ☐ 1. YES ☐ 2. NO

Do you normally purchase Personal Accident Insurance as part of your rentals? ☐ 3. YES ☐ 4. NO

Signature _____

Date _____



Avis features GM cars. Buick Regal.

We try harder. Faster.™

AVIS®

Flat rates are available at all Avis corporate and participating licensee locations in the contiguous U.S. and are subject to change without notice. These rates are not available in Manhattan between 1 PM Friday and 3 PM on Sunday and during holiday periods. $3 additional per day on rentals at Newark Airport, NJ; LaGuardia Airport, NY; JFK Airport, NY and all Manhattan, NY locations. Flat rates are nondiscountable. Cars subject to availability and must be returned to rental city or drop-off charge and higher rate will apply. Refueling service charges, taxes, optional CDW, PAI and PEP are not included. Renter must meet standard Avis age, driver and credit requirements.

3/85 Printed in U.S.A.

New Motrin® 800 TABLETS mg

ibuprofen

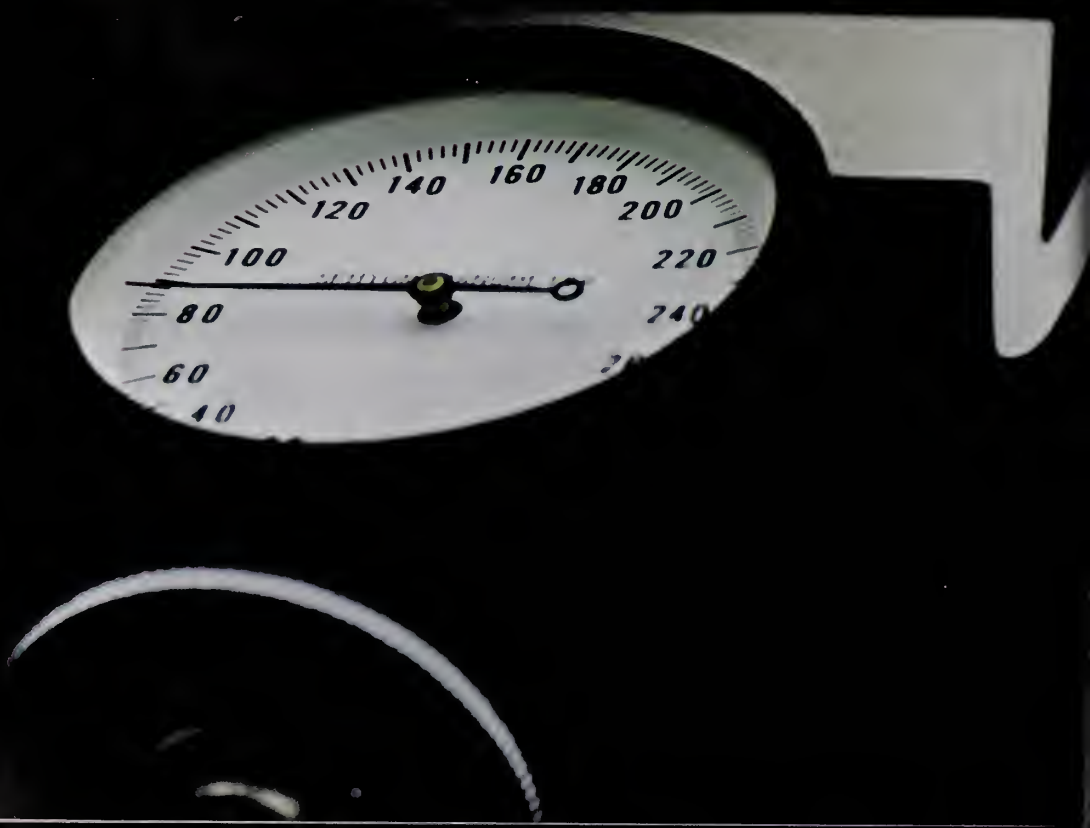
Extra strength
Convenience
Economy

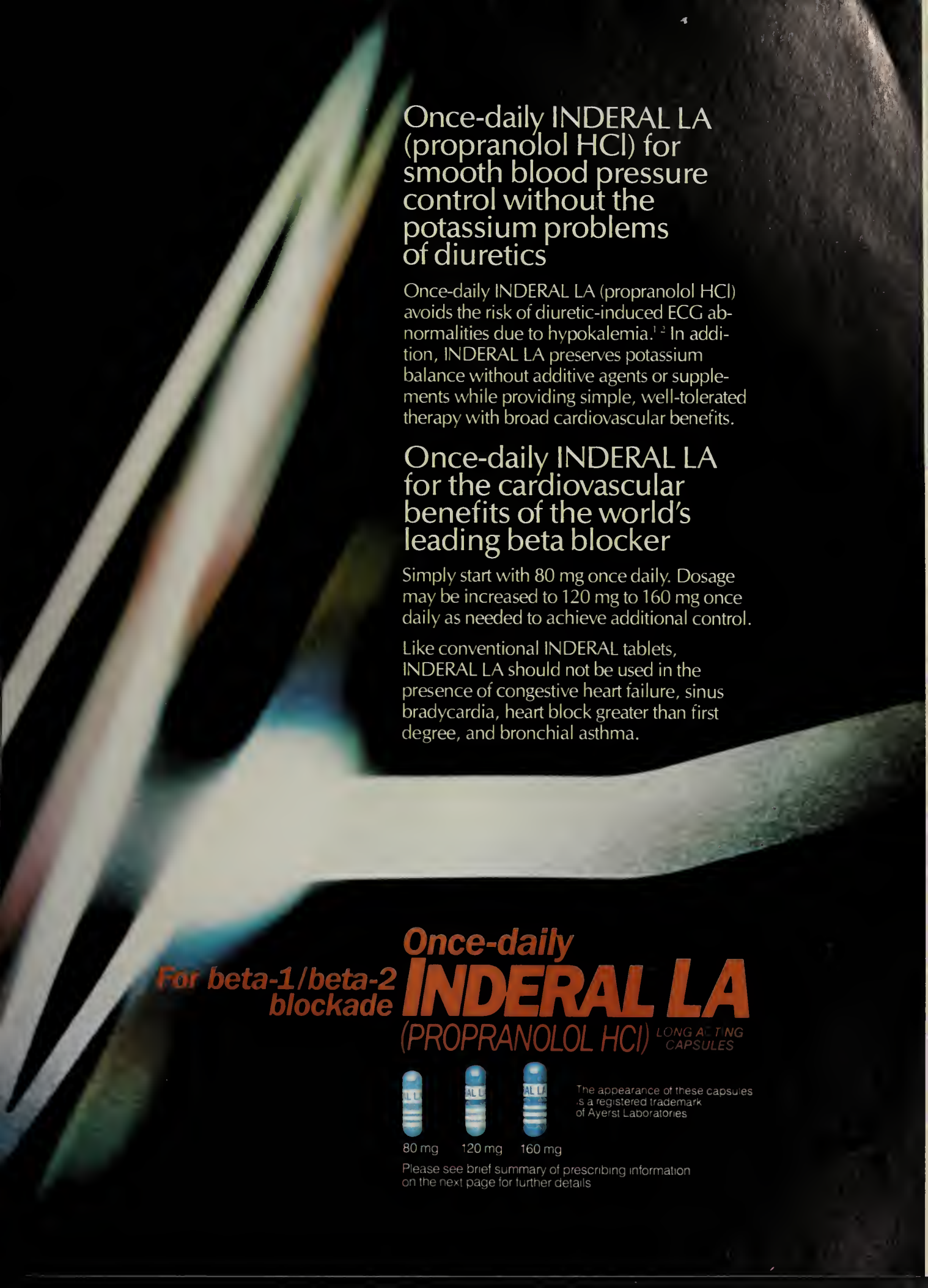
Upjohn

The Upjohn Company
Kalamazoo, Michigan 49001 USA

J-5491 June 1985

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories

Please see brief summary of prescribing information on the next page for further details

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Autoimmune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

9411/1184

The Health Maintenance Organization as a cost containment instrument: logic or illusion?

The Health Maintenance Organization (HMO) movement is enjoying a mighty resurrection.

An infusion of $464 million dollars of federal grants and loans which began with the Nixon administration catapulted the concept into its logarithmic growth phase and launched 150 HMOs during the 1970s. Then the pace of growth turned sluggish as enrollment suffered, financial problems arose, and 27 HMOs failed. The public cry for cost containment over the last 4 years, however, has revived HMOs and has transformed them into a highly vital, competitive force in the health care delivery system. Nearly 17 million people were enrolled in 337 HMOs by the end of 1984 — a 22% increase over 1983. Fifty-four additional HMOs became operational during the first three months of 1985. Florida now has 19 HMOs and had nearly 520,000 members at the end of 1984 — a 55.5% increase over 1983 and the largest percentage increase in the nation. By 1987, Florida is projected to have nearly 2 million enrollees and the nation is projected to have over 25 million HMO enrollees. The preponderance of HMO activity is concentrated in urban areas with populations greater than 500,000 people.

The political attraction of the HMO resides in the performance by the HMO of dual roles as both insurer and provider. Thus, the HMO assumes the financial risk for providing all medical care for the population it enlists. The assumption is that, by accepting financial risk, the cost of care will decrease. This assumption has yet to be certified as legitimate.

Three major types of HMOs exist. The first is the staff model which is a corporate structure that usually owns its own facility and hires physicians as employees. The corporation assumes the financial risk for any losses. The most common type is the group practice model in which the group contracts its services to the HMO and divides the risk for care among the partnership. The third model is the Independent Practice Association (IPA) in which individual private doctors or small groups operating out of their offices contract for care of patients. Fee-for-service payment is frequently, but not always, used in the IPA model. The individual doctors share any losses of the IPA.

What is the evidence that HMOs provide effective mechanisms for health care cost containment? ● The most extensive study of the cost containment benefits derived from HMOs was conducted by the Rand Corporation from 1976 to 1981.[1] The 1,580 patients included in the study were randomly assigned to 6 health care delivery groups. Group One patients received care on a fee-for-service basis. All care, both inpatient and outpatient, was provided for free. Participants in Groups Two, Three and Four also used fee-for-service physicians but these patients were required to co-insure (i.e., they had to pay part of their total health care bill). Group Two patients paid 25% of their annual inpatient and outpatient costs up to a maximum of $1,000 per family per year. Group Three patients paid 95% of the same costs with the same $1,000 limitation per family per year. Group Four patients paid 95% of their outpatient bills only up to $150 per person or $450 per family per year. Inpatient costs were totally covered. Groups Five and Six were enrolled in the Group Health Cooperative of Puget Sound (GHC) in Seattle, Washington. Group Five patients were new enrollees in the plan; Group Six patients were a random sample of GHC members in 1976. GHC is a pre-paid HMO in which all inpatient and outpatient services are provided by the annual enrollment fee.

The study results demonstrated the following: First, fee-for-service physicians use in-hospital patient care significantly more than do HMO doctors. The greatest differences existed in the patients in Group One who had all medical costs covered. In this group there were 83 hospital days per 100 persons versus 49 hospital days per 100 persons in Group Five (HMO group). Surprisingly, the lowest hospital utilization was in patients in Group Four, i.e., those who had to cover most of their outpatient costs but who had free inpatient care (28 hospital days per 100 persons). The second conclusion was that outpatient visits per person per year were slightly less for fee-for-service than for HMO physicians. Third, the imputed costs per patient per year varied significantly from $609 per participant in Group One (the free fee-for-service group who received all their care for free), to $413 per participant per year in the fee-for-service Group Four who had to pay 95% of their outpatient bills up to $150/person or $450/family per year. The HMO Groups, Five and Six, incurred an annual expense of $439 and $469 respectively per participant per year — less than in the first 3 fee-for-service groups.

The heuristic principles derived from this study are that cost containment can be accomplished with either reduction of hospital usage or by making the patient bear a major share of the outpatient cost risk. It demonstrates that the major cost containment mechanism of HMO doctors is a lower rate of hospitalization utilization. The number of outpatient visits is the same or slightly higher in pre-paid HMO groups. These findings are similar to those derived from a previous review of HMOs in 1978.[2]

There is one major difficulty with the Rand study — the patient selection. Excluded from the study were certain economically high-risk groups such as patients over the age of 62, those eligible for Medicare disability, those on end-stage renal dialysis programs, and those who were institutionalized. Such individuals consume a huge fraction of the American health dollar, and their exclusion from the study may taint the conclusions.

Luft reviewed the pre-1978 literature concerning the economics of HMO savings.[2] He also concluded that the total medical care costs are lower for HMO participants than for fee-for-service medical care. The cost savings flowed from lower rates of "discretionary" surgery and lower rate of medical admissions to hospital, but did not come from shorter hospital stays or from fewer outpatient visits. He could define no other attributes that made HMOs more efficient than standard insurance plans.

Do HMOs offer any other savings besides cost of hospitalization — such as lower use diagnostic services • These data are not available, but an approximate answer to this question was attempted by a study reported by Hlatsky et al.[3] Case summaries from 51 patients with chest pain were submitted to 91 cardiologists drawn from private fee-for-service practitioners, HMO physicians, and academic faculty members in the San Francisco-Oakland metropolitan area. Each physician was asked whether exercise thallium scintigraphy (a procedure costing about $600) and/or coronary angiography (a procedure costing about $3,000) were indicated in each patient. It was found that the HMO cardiologists recommended each procedure significantly less frequently than did private practice doctors. Academic physicians were intermediate between the HMO and private practice physicians. Outcomes — such as death, myocardial infarction, etc. — obviously could not be measured by the study design. Perhaps HMO physicians use costly diagnostic procedures less frequently than fee-for-service doctors. We have no way of determining if this is advantageous to the patient but the study does reveal a more frugal mind set for HMO physicians.

The quintessential issue in health care economics is, "What is the relationship between cost of care and patient medical outcome and/or economic benefit?" This issue has not been measured in any study.

One limited attempt to correlate medical outcome with payment mechanism was conducted in the Indian Health Service.[4] This study evaluated the performance of 11 medical care entities (2 HMOs, 3 fee-for-service private practices, and 6 government-financed Indian Health Service units) for the management of a very limited number of conditions: prenatal surveillance and counseling, infant immunization and well-baby management, treatment and followup of anemia and urinary tract infection, and screening for hypertension. The results showed that the size of the medical care organization correlated negatively with the quality of treatment and followup care. The payment mechanism showed no relationship to screening, treatment or preventive performance.

Do HMOs lower employers' costs of providing health care benefits? • Probably not. Iglehart[5] reported that Honeywell has calculated that the high rate of employee enrollment in HMOs in the Minneapolis-St. Paul area has cost the corporation millions because the monthly HMO bill must be paid whether or not the employee uses medical services. Honeywell's healthier employees enroll in HMOs; its less healthy elect self-insurance plans, and Honeywell must cover bills generated by both types of insurance. A very recent Louis Harris and Associates survey sponsored by the Kaiser Foundation[6] reports that 30% of executives feel that HMOs decrease employee benefit costs, 51% feel that HMOs have no effect on benefit costs, and 4% feel that

HMOs have increased benefit costs. A synthesis of these reports seems to indicate that subscription to HMO plans does not benefit the employer who provides the health care costs for his employees.

The Honeywell experience and the Rand study quoted earlier identify another problem associated with evaluations of the economic benefits of HMOs, i.e., the possible drift of low utilizers of health care into HMOs. A study reported by Jackson-Beeck et al. in *JAMA*[7] seems to confirm that HMOs attract people who consume fewer health care resources. High-use health care consumers seem to prefer specialists who frequently are unavailable to HMO patients. Certain high-risk patient groups such as the Medicare beneficiaries were excluded from HMOs until the last 18 months. Medicaid patients have been enrolled by only 20% of HMOs and Medicaid patients still comprise only 2% of the HMO population versus 10% of the general population. HMO experience indicates that the hospital admission rate for Medicaid patients is more than 50% greater than for the typical HMO patient, and total in-hospital days is 325% greater. Furthermore, more than half of Medicaid patients leave the HMO after 1 or 2 years of enrollment. Those who leave in the first year consume 550% more hospital services than the typical HMO enrollee! Obviously, exclusion of such high-risk people from enrollment grants HMOs an economic advantage that other providers who care for such individuals lack. As the Medicare-aged population enters HMOs, the cost advantage currently enjoyed by HMOs may rapidly evaporate.

One recurrent criticism against HMOs is that they achieve cost savings by offering low-grade care. The literature disputes this criticism[8,9] but the majority of studies concern populations in which most people are healthy except for transient illness. One recent study[10] which compared the management of rheumatoid arthritic patients by private rheumatologists and Kaiser rheumatologists in the Northern California area, revealed no differences between the two doctor groups in terms of hospital days, frequency of surgery, gold shots, arthrocentesis, or utilization of X-ray and laboratory services. Unfortunately, patient outcomes were not measured. This study failed to show any financial advantage of the HMO over the fee-for-service provider and suggested that Northern California HMO specialists treat chronic diseases such as rheumatoid arthritis with the same intensity as private physicians. Whether the same quality of specialists is available to all HMOs throughout the nation as exists in Northern California is another unknown.

Do HMOs succeed in resisting the inflationary cost spiral? • By limiting in-hospital costs, HMOs frequently offer lower initial rates for health care (currently about $200 per month per family nationwide) than other insurors. They have not been able to resist the effects of inflation, however, and their annual rate increases closely resemble those of other health insurance programs.

How should the individual physician confront the HMO concept? Should he or she ignore it, reject it, or join it? • The following answers are a composite which has been formulated from discussions with a sampling of private practice leaders in Minneapolis-St. Paul and California.

HMOs will survive and co-exist as a health care delivery system within a pluralistic medical care society. They will not displace fee-for-service private practice. If a physician practices in a large urban area, wisdom dictates the consideration of joining one or more HMOs. Younger physicians, who are discovering that starting practices are difficult in popular urban areas, might consider joining a staff model HMO. Reimbursement levels, however, are often low for such physicians. In the Twin Cities area, some HMOs offer an initial salary for family physicians in the $35,000 to $40,000 range. Older, well-established physicians do not experience the same coercion to join as do the younger physicians with limited patient followings. HMOs do increase a doctor's referral base — in contrast, Preferred Provider Organizations rarely expand a physician's practice. Those certain physicians who may be philosophically opposed to HMOs should recognize that HMOs are not inherently wicked or unethical. Furthermore, veneration by books of history or one's colleagues cannot be gained by financial martyrdom. A physician situated in a major urban area, therefore, should consider joining an HMO providing it can increase his present patient population or prevent him from losing a significant portion of his patients.

When enlisting in an HMO, remember that Independent Practice Associations (IPAs) make the individual physician responsible for economic losses. Economic risk is nil for staff model HMOs but can be real in the group or IPA models. Most HMOs are NOT making money; 60% of all federally-qualified HMOs failed to show a cumulative operating surplus over the past 3 years. Furthermore, risk is not limited merely to underestimating health care usage and the rate structure. Malpractice risk can also be substantial; e.g., the malpractice suit rate against certain Kaiser HMO organizations is substantially higher than the rate against fee-for-service practitioners in the same locales. Prior to signing a contract with an HMO or Preferred Provider Organization (PPO), you should obtain from the American Medical Association and read their booklet, "A Physician's Guide for Preferred Provider Organizations," which contains a list of caveats; check this list against the fine print of any contract.

Most doctors in smaller or rural communities do not yet feel compelled to join an HMO, but the current reprieve is probably temporary.

In summary, HMOs do reduce health care expenses for their enrollees by reducing hospital utilization. There is no evidence that they reduce the cost of outpatient care. The cost savings differential between HMOs and traditional health insurance schemes will narrow significantly within the next few years because of convergence of rates of hospital utilization and because of the intense competition for the insurance dollar. HMOs, however, are not the answer to the health care cost problems of this country. They do not answer the problems of the high cost for the elderly or for the terminally ill or for the chronically ill or for the medically indigent, since HMOs do not serve these people. The costs and fees for those dedicated to the care of EVERYONE will necessarily be higher than that of HMOs, whose primary patient population consists of the medically well-manicured.

References

1. Manning, W.G.; Leibowitz, A.; Goldberg, G.A., et al: A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services. N. Engl. J. M 310(23): 1505-1510, 1984.
2. Luft, H.S.: How Do Health-Maintenance Organizations Achieve their "Savings"? N Engl. J. M. 298(24):1336-1343, 1978.
3. Hlatky, M.A.; Lee, K.L.; Botvinick, E.H et al: Diagnostic Test Use in Different Practice Settings A Controlled Comparison. ARch. Intern. Med. 143:1886-1889, 1983.
4. Nutting, P.A.; Burkhalter, B.R.; Dietrick, D.L., et al.: Relationship of Size and Payment Mechanism to System Performance in 11 Medical Care Systems. Medical Care XX(7):676-690, 1982.
5. Iglehart, J.K.: Health Policy Report. The Twin Cities' Medical Marketplace. N. Engl. J. M. 311(5):343-348, 1984
6. Health Market Survey 2(10):1-8, May 30, 1985.
7. Jackson-Beeck, M.; Kleinman, J.H.: Evidence for Self-Selection among Health Maintenance Organization Enrollees. JAMA 250:2826-2829, 1982.
8. Cunningham, F. and Williamson, J.: How Does the Quality of Health Care in HMOs Compare to that in Other Settings? Group Health J. 1:4-25, 1980.
9. Luft, H.S.: Health Maintenance Organizations: Dimensions of Performance. New York: Wiley-Interscience, 1981.
10. Yelin, E.H.; Henke, C.J.; Kramer, J.S., et al.: A Comparison of the Treatment of Rheumatoid Arthritis in Health Maintenance Organizations and Fee-For-Service Practices. N Engl. J. M. 312(15):962-967, 1985.

Jacques R. Caldwell, M.D.
Daytona Beach

The AMA Announces...

20 NEW PATIENT MEDICATION INSTRUCTION SHEETS

Now there are 60 PMIs available to help educate your patients about the drugs you prescribe for them

Your patients want to know!
Your patients need to know!
Now you can contribute to better patient education by distributing PMI sheets. PMIs are handy, tear-off drug information sheets that are meant to supplement your verbal instructions to your patients.

PMIs help to improve compliance, strengthen your relationship with your patients, and reduce the number —but enhance the importance—of the call backs you receive.

Quick, simple, balanced drug information

PMIs contain scientifically sound information regarding the drugs you most frequently prescribe. To prevent confusion, particular care has been taken to make PMIs easy-to-understand and easy-to-read. To avoid needlessly alarming the patient, PMIs do not list all adverse drug reactions or less well-documented and rare reactions.

Benefits you and your patients

It is the proper and vital role of the physician to provide drug use information to patients. While face-to-face counseling is an indispensable part of patient education, counseling supplemented by written information has been shown to be the most effective.

PMIs help to improve patient compliance, strengthen your professional relationship with your patients, and reduce the number—but enhance the importance—of the call backs you receive.

ORDER YOUR PMIs TODAY!

Complete this order form and mail it with your payment to:

PMI Order Dept.
American Medical Association
P.O. Box 8052
Rolling Meadows, IL 60008

(Please print)

Name _____

Address _____

City _____

State/Zip _____

Number of pads	PMI Number and Title
_____	027 Allopurinol
_____	018 Belladonna Alkaloids and Barbiturates
_____	012 Benzodiazepines
_____	004 Beta-Blockers
_____	009 Cephalosporins—Oral
_____	032 Chloramphenicol—Oral
_____	017 Cimetidine
_____	031 Clindamycin/Lincomycin—Oral
_____	016 Corticosteroids—Oral
_____	006 Coumarin-Type Anticoagulants
_____	005 Digitalis Medicines
_____	034 Ergot Derivatives
_____	010 Erythromycin
_____	026 Ethosuximide
_____	001 Furosemide
_____	024 Guanethidine
_____	022 Haloperidol
_____	023 Hydralazine
_____	035 Indomethacin
_____	015 Insulin
_____	038 Iron Supplements
_____	033 Levodopa/Carbidopa and Levodopa
_____	021 Lithium
_____	014 Methyldopa
_____	030 Metronidazole
_____	040 Nifedipine
_____	013 Nitroglycerin Sublingual Tablets
_____	011 Nonsteroidal Anti-Inflammatory Drugs
_____	007 Oral Antidiabetes Medicines
_____	003 Penicillins—Oral
_____	036 Phenylbutazone/ Oxyphenbutazone
_____	019 Phenytoin
_____	037 Quinidine/Procainamide
_____	020 Sulfonamides
_____	008 Tetracyclines
_____	002 Thiazide Diuretics
_____	029 Thyroid Replacement
_____	025 Valproic Acid
_____	039 Verapamil
_____	028 Xanthine Derivatives—Oral

NEW PMIs now available!

_____	049 Acetaminophen
_____	050 Amiloride and with Thiazide
_____	043 Antihistamines
_____	047 Aspirin
_____	044 Bronchodilator Aerosols
_____	054 Clonidine
_____	048 Codeine
_____	056 Diphenoxylate with Atropine
_____	057 Isotretinoin
_____	059 Methotrexate (for psoriasis)
_____	055 Methysergide
_____	045 Pentazocine—Oral
_____	041 Phenothiazines
_____	058 Potassium Supplements
_____	052 Prazosin
_____	046 Propoxyphene and with Aspirin or Acetaminophen
_____	053 Spironolactone and with Thiazide
_____	060 Steroid and Antibiotic Eye Drops
_____	051 Triamterene and with Thiazide
_____	042 Tricyclic Antidepressants
_____	Total number of pads (5 pad minimum, 50 PMIs per pad)
$ 1.00	Per pad
$ _____	Subtotal
$ _____	Residents of IL and NY must add appropriate sale tax to subtotal
$ _____	Total payment (check enclosed)

☐ NOTES & NEWS

FMA Committee on Impaired Physicians to hold workshop

The FMA Committee on Impaired Physicians will conduct the sixth in its series of "Workshops on Intervention with Impaired Physicians" in Orlando in September.

The two-day program will be presented on Saturday and Sunday, September 28-29, at the Orlando Hyatt House, according to Guy T. Selander, M.D., of Jacksonville, Chairman of the Committee. The Hyatt is located at the intersection of Interstate 4 and U.S. 192 west of Orlando and near the entrance to Disney World. The program will begin at 9:00 a.m. and end at 5:00 p.m. each day.

Dr. Selander said the program will cover, among other things, legal responsibilities, recognition of chemical dependency, substances commonly abused, intervention techniques and aftercare. IPP Medical Director Roger A. Goetz, M.D., is course director.

The program was endorsed by T. M. "Dan" Daniel, M.D., Chairman of the Council on Hospital Medical Staffs.

"This program is of special importance to hospital medical staffs," Dr. Daniel said. "Medical staffs often are faced with the problem of an impaired physician in their midst, and all too often they are not sufficiently prepared to deal with it. The Intervention Workshop should be of great value to medical staffs in this regard."

There will be no registration fee, and AMA Category I CME Credit will be offered. Persons desiring overnight accommodations should call the Hyatt House at (305) 396-1234. Be sure to tell the reservation clerk that you are with FMA in order to qualify for the special rate of $70 per night.

In order to register for the Workshop, please send name, address and hospital you are representing to: Mr. Edward D. Hagan, Director of Medical Services, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida, 32203, or call (904) 356-1571.

Frank H. Netter, M.D., honored by Georgetown University

Accompanied by an overwhelming applause, world-renowned medical illustrator Frank H. Netter, M.D., of Palm Beach, Florida received an honorary Doctor of Science degree from Georgetown University School of Medicine at the school's recent commencement exercises in Washington, D.C.

When conferring the degree, Rev. Timothy S. Healy, S.J., President of Georgetown University, quoted Ralph Waldo Emerson, stating, "In the hands of the discoverer, medicine becomes a heroic art." Rev. Healy added that, "In the hands of Frank Netter that 'heroic art' is indeed discovered and the entire medical community has reaped the rewards.

Regarded by many as the world's greatest medical illustrator, Dr. Netter is best known for his widely acclaimed *Ciba Collection of Medical Illustrations*. This nine-book series covers the anatomy, embryology, physiology, pathology and diseases of man, body system by body system.

Dr. Netter, who graduated from the City College of New York, studied art at the National Academy of Design and the Arts Student League and worked as a free-lance commercial artist before entering New York University Medical College, where he earned his M.D. degree in 1931.

He completed an internship and residency in general surgery at Bellevue Hospital in New York before concentrating totally on art. For the past thirty-five years he has been under exclusive contract to the Ciba-Geigy Corporation.

Currently, Dr. Netter is working on additional books in the Ciba Collection; the *Nervous System Part II*, and the *Musculoskeletal System, Part I*. He also continues to illustrate Ciba-Geigy's bimonthly journal, *Clinical Symposia*.

"Eat your spinach" can be terrible advice for sulfite-sensitive kids

Coughing, gagging children thought to be choking on food actually may be in the throes of an allergic reaction to sulfiting agents used to preserve foods.

A 7-year-old boy from Maryland who violently coughed, retched and vomited minutes after eating vegetables from a restaurant salad bar is the world's

youngest documented victim of sulfite sensitivity, according to an article in the May issue of the *Annals of Allergy*.

Allergic reaction to sulfiting agents previously had been reported only in adults and children over 12, said Dr. Stanley I. Wolf, co-author of the *Annals* study. The *Annals* is published by the American College of Allergists.

Previous cases of sulfite sensitivity in young children may have gone unrecognized because the symptoms disappear rapidly and may have been attributed to choking on food, said Dr. Wolf, Clinical Professor of Child Health and Development at George Washington School of Medicine.

Sulfiting agents are used in some restaurant salad bars and in some packaged food to prevent browning, eliminate bacteria and increase storage life. Many restaurants have discontinued use of the controversial additive because it may cause adverse reactions, ranging from hives to anaphylactic shock, in sensitive persons.

Before diagnosis, the 7-year-old boy had suffered symptoms on at least five separate occasions after sampling salad-bar fare. His mother, who at first thought the boy was choking on food, told doctors that, on each occasion, the boy's symptoms disappeared within 20 to 30 minutes after onset.

His allergy was confirmed when, under medical supervision, he was given an oral dose of the same sulfiting agent used in the restaurant and his symptoms resurfaced. The boy also tested positive when given a skin test using the same agent. Skin tests alone are not always conclusive, Dr. Wolf said.

Dr. Wolf advises parents and pnysicians to suspect sulfite sensitivity if a child suffers coughing, vomiting, itching, hives, swelling or asthma-like distress after eating salad-bar or other foods containing sulfiting agents. While facial flushing is a symptom of this allergy in adults, a sensitive child may turn pale, Dr. Wolf said. Asthmatics should be especially alert to these symptoms because studies show 5% to 10% of all asthmatics are hypersensitive to sulfiting agents.

A child with these symptoms should be taken to an emergency room or a physician for immediate treatment.

Major food categories to which sulfiting agents are often added include, but are not limited, to: Avocado dip and guacomole, beer, cider, cod (dried), fruit (cut-up fresh, dried or maraschino-type), fruit juices, purees and fillings, gelatin, potatoes (cut-up fresh, dried, frozen or canned), salad dressing (dry mix), relishes, sauces and gravies (canned or dried), sauerkraut and cole slaw, shellfish (fresh, frozen, canned or dried), clams, crab, lobster, scallops;, shrimp, soups (canned or dried), vegetables (cut-up fresh, frozen, canned or dried), fresh mushrooms, wine vinegar, wine, and wine coolers.

The Food Allergy Committee of the American College of Allergists suggests the following preventive measures:

- When ordering food in a restaurant, ask if sulfiting agents are present in the specific item you desire. Most restaurants have discontinued their use upon recommendation of the National Restaurant Association. However, they are often present in items purchased from suppliers. Press the manager for a definite answer, but he may not be aware of sulfites added by suppliers.
- If the manager seems in doubt or you do not receive a definite answer, order an item which is not sulfited such as chicken, eggs, meat or cheese.
- Read labels on all processed foods. Sulfiting agents may be mentioned on the label and their presence will be indicated by one or more of the following terms: sulfur dioxide; potassium bisulfite or potassium metabisulfite; sodium bisulfite, sodium metabisulfite or sodium sulfite.

FMA establishes medical/legal hotline

The Florida Medical Association Board of Governors and the House of Delegates have approved the establishment of a medical/legal "hotline" to serve the FMA membership and component county medical societies. The purpose of the"hotline" is to provide a designated direct line to FMA's legal department to assist members in obtaining answers to their medical/legal questions. Questions dealing with the Medical Practice Act, or with issues confronting physicians as they practice will be addressed, if possible, over the phone. Frequently, however, there will be instances where the caller will be asked to put his question in writing and a written response to the caller will be sent as soon as possible. This is to ensure that the answer being provided is complete and responsive, particularly when the issue is multifaceted.

The "hotline" will operate from the FMA Headquarters Office during normal business hours (8:30 a.m. - 4:45 p.m.), weekends and holidays excluded, and available to receive calls from any member or component county medical society. The "hotline" number is (904) 356-0056.

The legal department cannot answer questions dealing with a physician's personal and private business or family matters. The legal department is also not permitted to participate in any court hearings in support of a member unless such action is approved in advance by the FMA Board of Governors.

The FMA is pleased to provide this valuable service and hopes that it will be of assistance to its membership and component county medical societies.

JCAH seeks qualified physicians as surveyors

Interested in an opportunity to enhance your knowledge of the nation's health care system while helping to improve patient care? If so, you should consider becoming a physician surveyor for the Joint Commission on Accreditation of Hospitals (JCAH).

The JCAH is currently recruiting both full-time and part-time physician surveyors for its Hospital Accreditation Program. As a surveyor, you'll be part of a survey team that visits facilities throughout the country to determine their progress in meeting JCAH's standards in patient care. During the accreditation survey, you'll discuss your survey findings with key medical staff members and hospital personnel and provide consultation and education. Your findings will help JCAH's Board of Commissioners to make a final accreditation decision.

To become a physician surveyor, you need:

- a current medical license;
- at least 15 years of service on a hospital medical staff with committee and leadership responsibilities;
- extensive clinical and patient care management experience;
- strong oral and written communication skills; and
- excellent physical health.

The benefits of becoming a physician surveyor include a yearly salary and per diem expenses, noncontributory life insurance, medical insurance, a retirement plan, and an optional, tax-sheltered annuity plan. In addition, you'll enjoy a liberal vacation and holiday policy.

The position also offers many educational opportunities and challenges. As Donald Weiss, M.D., a physician surveyor, comments, "As a surveyor, I am continuously meeting with physicians who are eager to show me the latest techniques in surgery, nuclear medicine, drug therapy, and a number of other medical areas.

"Most importantly, however, I feel that as a surveyor, I am helping medical staff members and other hospital personnel become aware of the value of voluntary assessment and how they can help improve the quality of care provided within their facilities."

If you are interested in this important challenge and career opportunity, please send a copy of your curriculum vitae to: Kristin V. MacRae, Director of Personnel, JCAH, 875 North Michigan Avenue, Chicago, Illinois 60611, (312) 642-6061.

DEAN'S MESSAGE

Brother against brother?

In June every year, thousands of young men and women graduate from medical school. In 1985, slightly over 16,000 people received their M.D. degree in the United States and entered graduate medical education.

Never before have young physicians entered the mainstream of medicine with so many threats to their profession as exist today. Each physician can identify these threats — malpractice crisis, hospital-physician relations, cost containment, new technology, consumer group organizations, health maintenance plans, open marketing by physicians, and in some communities physicians are even attempting to restrict the practice of other physicians using legal mechanisms. In our own state, it appears that the corporate practice of medicine is now legal. What's next?

Are we rapidly returning to the spirit of the Civil War when it was "brother against brother, father against son?" Will physicians be divided into two camps — fee-for-service *versus* corporate medicine? Will a schism develop between physicians that exists between hospitals? Will the battle lines drawn by competing hospitals pit medical staff against medical staff — "brother against brother, father against son?" The profession may be able to preserve and protect that which is good.

How? There are no easy answers. However, it is crystal clear that very active involvement in the local medical society, Florida Medical Association, American Medical Association, and your specialty organization are keys to the future. Encourage and invite young physicians to be active in medical organizations — listen to them, involve them. If we do not work together, our divided house will surely fall.

William B. Deal, M.D.
Dean and Associate Vice President
University of Florida College of Medicine

ENCORES!

Passive smoking: has the threat proved true?

Cigarette smoking is our greatest public health problem. From lung cancer to premature menopause, emphysema to ulcers to crow's feet, the list of its nasty sequelae seems to grow every year.

Nonsmokers look on the habit with pity or contempt, plus an occasional flash of annoyance when smoke drifts too close. Except for some asthmatics, though, few see it as a personal danger. Researchers are not so confident. Hints that someone else's smoke can be more than an irritant have sprinkled the literature since the late 1960s.

As recently as 1979, however, the Surgeon General's report reassured us that healthy nonsmokers show "little or no physiologic response" to passive smoking. Five years ago, three studies promoted the issue from a minor to a major controversy, where it remains today. It's still not clear if passive smoking leads to long-term clinical disease, but each study raised ominous questions.

Flow rates flag in passive smokers • From 1969 to 1979, researchers at the University of California at San Diego evaluated pulmonary function in 2,100 smokers and nonsmokers. Measuring forced mid-expiratory and end-expiratory flow rates, they charted the usual deterioration from abstainers through light, moderate, and heavy smokers. But since nonsmokers were divided into those who worked more than 20 years around smokers and those who did not, the results also showed the effect of chronic passive smoking. It was not good. Not only did passive smokers score lower than controls, their flow rates were similar to those of light smokers.

Expiratory flow rate is the most sensitive measure of small airway function. A drop is the earliest abnormality shown by a smoker's lung. Passive smokers in this study had a small but significant impairment — too little for clinical disease, but enough to support the conclusion that chronic exposure to tobacco smoke at work harms the nonsmoker.

Parental smoking called into question • Also in 1980, Harvard researchers reported on the relation between respiratory illness, parental smoking, and pulmonary function in children. In their study, children whose parents smoked had a lower forced expiratory flow (FEF) and a higher incidence of persistent wheezing. In fact, parental smoking was the strongest predictor of a low FEF — stronger than a child's history of persistent wheezing, lower respiratory disease, or asthma.

This was not the first such report. Over the previous decade half a dozen surveys from Britain and the U.S. found more respiratory illness in children of smokers. Since then, it's become clear that bronchitis, pneumonia, and other lower respiratory diseases are significantly more common in children less than one year old with one or two smoking parents — and probably more common during the second year.

Studies at older ages are not unanimous, but most show that children of smoking parents have more acute respiratory illness, chronic cough, phlegm, and/or persistent wheeze. One ingenious French study used tonsillectomy as a measure of recurrent respiratory illness. When 4,000 children between the ages of 10 and 20 were asked (1) if they had had a tonsillectomy and/or adenoidectomy, and (2) if their parents smoked, their answers revealed a surgery rate of 28%, 41%, and 51% for zero, one, and two smoking parents, respectively.

Viewing the evidence, the latest Surgeon General's annual report agrees that passive smoking has a measurable ill effect on the development of lung function in children. The data are impressive enough to suggest that pediatricians include parental smoking habits in a child's medical history. More than one expert urges doctors to tell parents of children with recurrent respiratory illness to quit.

Does passive smoking contribute to cancer? • Idle speculation until 1981, the link between passive smoking and cancer erupted into a heated debate that persists with no clear winner. The trigger was a study showing that women whose husbands smoked more than a pack a day died of lung cancer twice as often as controls.

Appearing in the *British Medical Journal*, this conclusion was drawn from a massive survey of 265,000 Japanese done between 1966 and 1979. It explored the health consequences of social factors, such as occupation, marital status, and drinking and smoking habits, so there was no special attention paid to passive smoking.

The Tobacco Institute challenged this finding, backing its skepticism with an analysis by an outside expert who cast doubt on the statistical methods. Other experts came to the survey's defense, and both the study and the quarrel became an international news event.

Also in 1981, a small Greek study concluded that wives of smokers tripled their risk of lung cancer. Hong Kong researchers found no increased risk, nor did an American Cancer Society report that evaluated two large surveys from the 1950s and 1960s. A 1984 cooperative study of lung cancer in nonsmokers found an increased risk in men exposed to smoke at work. Unfortunately, researchers failed to ask about passive smoking until the eighth year of their ten-year project. The other studies are also incomplete. None was originally designed to investigate passive smoking.

The two-cigarette threshold • In 1983, a National Institutes of Health conference concluded that the effect of passive smoking on respiratory function "varies from negligible to quite small." Researchers are frustrated by the small doses they must deal with. A nonsmoker heavily exposed to tobacco smoke probably inhales the equivalent of two cigarettes a day.

Two seems to be a threshold level. According to a National Cancer Institute analysis of many studies, a person can smoke two cigarettes a day without measurably increasing his mortality risk above that of a nonsmoker. The key word is "measurably." There may be toxic effects at lower doses, but today's methods cannot recognize them. Tomorrow's may be more sensitive.

Hazardous or not, smoky air is unpleasant. While it's no longer considered eccentric to complain, there are more psychological barriers than we realize. Only one third of Americans smoke, yet a survey of nonsmokers found that most believe they are in the minority.

But the atmosphere is changing. Five years ago, statewide anti-smoking referendums were always soundly defeated. Nowadays, despite massive spending by tobacco companies, the margins of defeat have narrowed dramatically.

Legislators have responded to this change. Minnesota, Utah, Connecticut, and Arizona, plus over 30 cities and counties, have laws restricting smoking in public areas. In San Francisco, an employer must satisfy a nonsmoker's complaint, even if it means banning smoking entirely. A similar law recently passed in Los Angeles. A few companies have deciced to prohibit smoking entirely, and some — notably hospitals — prohibit smoking both on and off the job. Prospective employees interviewed for job openings simply will not be hired if they admit to smoking. A number of companies have offered financial rewards and other incentives to smokers who quit.

If progress continues, cigarette smoking could become a problem restricted to smokers themselves. Nonsmokers may sympathize, but they are increasingly unwilling to share the smoke.

Mike Oppenheim, M.D.
Los Angeles, California

Reprinted with permission from *Respiratory Medicine Today*, Vol. 1, No. 3.

Too many of us?

We physicians have been told, by a seemingly knowledgeable study panel, that our profession is facing an overabundance of practitioners by the year 1990. We have been told this again and again. In fact, I am becoming rather tired of hearing of our upcoming physician surplus. Perhaps those who preach this doctrine feel that they must keep calling it to our attention so we do not forget it. However, since hearing of this dreadful threat, I have been giving some thought to the problem. Some of the proposed solutions include closing some "marginal" medical schools and assigning quotas to each medical school. Other solutions have been offered — some of which are quite complex.

After some consideration of the problem, I think I have solved it. Before I describe this brilliant plan, however, let us think back to our reasons for selecting a career in medicine in the first place. To our untrained minds, medicine seemed very glamorous. To be summoned to the patient's hospital room, rushing in at the very last moment and administering the lifesaving injection, and to hear our names paged all over the hospital — these are heady experiences. It may be that you entered medicine for more altruistic reasons, perhaps to better the human race. No matter — when we got into medicine, we all found the same thing. What a disappointment it was to learn how really mundane the day-to-day practice of medicine is.

People would never suspect, watching one of the popular soap operas on television, that a large portion of usual medical care has to do with flatus, phlegm, and Foley catheters. Rather than addressing the commonplace problems of emesis-basin medicine at the bladder, bowel, skin, bedpan, and catheter level, the media ply the American public with scientific advances and breakthroughs or, on the other side of the coin, provide stories of medical malfeasance generating enormous sums of money by way of litigation. Although most television shows carefully screen us from life's more basic functions, the advertisers who sponsor the shows certainly do not spare us. There are more than enough commercial advertisements for expectorants, laxatives, sanitary napkins, and hemorrhoidal preparations to serve as a constant reminder of what people are really concerned with.

Dr. Richard Lee of Children's Hospital, Buffalo, speaks of this as the "bedpan gap." Throughout medical training, our esteemed professors, either through inexperience or embarrassment, speak of the monumental and tend to ignore the mundane aspects of medical and surgical practice. They dwell on the desultory, the diverse, and the dramatic aspects of our craft, leaving the less glamorous part of medicine to be imparted to us by others. I am not implying that this is necessarily wrong, but where then does a medical student learn about the everyday runny nose and sore back and the type of medicine to use for hemorrhoids?

Nearly all of us who are "a little older" came to appreciate the real world of medicine on the wards of a hospital. The night nursing supervisor taught me the tricks of passing a gastric tube, restarting an IV, and inserting a urinary catheter and what sterile technique meant. Although I still revere and respect nearly all of my medical school professors, I often

think that the nurses at the hospital taught us almost as much, but at much less cost and on a different level.

Since our clinical partners, the nurses, have succumbed to the fantasy world (the same one physicians are in) of extra degrees, superspecialization, and "extended care plans," I wonder where the new medical school graduates will get their intoduction to the sights, smells, and stressful needs of sick people? I now have fond memories of the fussy spinsterhood of Miss Jones, the head nurse on the urology ward of the hospital where I interned. When we lowly interns came on her ward, we washed our hands and addressed all patients, many of whom were outcasts and indigents, as "mister" so and so. She would tolerate no less, and on that ward she was the boss. Even the urology attendings avoided offending Miss Jones. If there was ever a patient advocate, before that term became popular, she was one! To a chronically tired intern who always seemed to be two patient workups behind, Miss Jones's fussiness was not appreciated, but to the patients on her ward, she was the epitome of gentle, competent care.

Getting back to my solution to the physician surplus, I contend that if aspiring premedical students were aware of how common and ordinary most of what physicians do is, the number of medical school applications would drop precipitously. As it is now, much of the public perceives medicine as constantly poised on the brink of fabulous scientific breakthroughs. These perceptions are produced primarily by the media, which continually titillate the public into expecting more from medicine than is currently feasible. As an example, I recently read an article in the lay press about what a miraculous and lifesaving procedure a bone marrow transplant is, without more than a mere mention in passing of its drawbacks, expense, and frequent failures.

I suggest that we make up a folder to be mailed to each premedical student in his or her sophomore year of college. Sending it at that time would allow students to change their major without too much difficulty. We might call it the "Practitioner's Premedical Predictive Package," or the "Four-P" test for short. The folder might contain several "scratch and smell" patches representing, for example, the odor of a fungating breast lesion, the smell of apurulent abscess, and concentrated body odor. It should also include several color plates showing severe trauma cases, maybe an anencephalic infant, and a radical mastectomy. Next we could include a tape recording of some of the sounds common to medicine, such as the sound of a bone saw removing a window in the skull, the sounds of children being immunized, and the disconnected rambling speech of a schizophrenic. Finally, the last page of the folder should list a few of the situations physicians frequently must face. For example, what do you say to the pregnant woman who, by ultrasound, has just been discovered to have a fetus that is grossly abnormal? Whose instructions do you follow when the patient requests to be told the truth and the family members all stoutly insist that you should not disclose the nature or severity of the disease to the patient? What do you say to the husband of a young woman with two small children who has just been determined by biopsy to have inflammatory carcinoma of the breast?

I believe it would be easier to deal with the physician surplus by reducing the number of students entering medical school than by reducing the number of approved residencies, as our current method dictates. One danger in the current method is that it may force medical school graduates into general or family medicine by default. The field of primary care is rather demanding, and physicians who are not ready to make the commitment to this type of practice may well do more harm than good if they are forced to enter this field!

If students decide to continue into medicine, despite forewarnings, how will they succeed in overcoming bedpan gap? It is very difficult to do the extraordinary if we cannot do the ordinary. Somewhere along the line, young physicians need to learn that they will see 1,000 runny noses before a patient with nasopharyngeal cancer comes along and that hemorrhoids are apt to be a much larger part of their practice than AIDS.

When you hear hooves approaching, look for horses not zebras. Day-to-day medical problems constitute the "stuff" of medical practice, and much of that is unglamorous. If it were possible for us veteran physicians to make available to premedical students some of the sights, sounds, and smells of everyday medicine and impress on them the ordinariness of many of our day-to-day activities, we might just be able to solve our "overpopulation" problem by ourselves and keep the federal government out of it.

J. Mostyn Davis, M.D.

Reprinted with permission from *Postgraduate Medicine*, Vol. 77, No.6.

Will the real family physician please stand up

With the impending overabundance of physicians and the rapid proliferation of alternative health care delivery systems, everyone wants to be a family physician. Free-standing emergency centers advertise as your neighborhood family doctor. Health maintenance organizations proclaim that enrollees will have their own family doctor. Surgical subspecialists

who cannot obtain hospital privileges in their field open an office to practice family medicine. While thinking about this problem, the old TV show "To Tell The Truth" came to mind. Three contestants tried to fool the panel who were trying to guess the identity of the real guest. After they made their choices, Gary Moore, the host, would say, "Would the real Mr. Smith please stand up." As many times as not the panel was wrong. So it is today with family practice; no one is sure which one of us is the real family physician.

There is no law governing what label a physician places on himself. Many internists call themselves cardiologists even though they are not board certified in that subspecialty. There is no law that says an orthopedic surgeon must be board certified to practice orthopedics. Many general practioners call themselves family physicians even though they are not board certified in our specialty. Until 1978 a GP could take the boards in family practice by practicing from three to six years after medical school. After 1978, however, this pathway closed and now only those who complete a full three-year family practice residency are eligible to take the board exam. Obviously the title family physician is being applied to many more individuals than are board certified.

The specialty of family medicine is so well established now that it need not be the dumping ground for any physician who has a medical license. It's time we throw out the idea that anyone can practice family medicine. Departments of family practice in hospitals should be for family physicians and not for any misfit who wants hospital privileges.

If HMO's and free-standing centers are found to be employing retired neurosurgeons and pathologists as their "family doctors," it is incumbent upon us to bring this to the attention of the public. I don't deny that plenty of good GP's may originally have been trained in different specialties and practice high quality family medicine. Likewise, some board certified family physicians may be borderline practitioners. A doctor who has made the effort to take the boards and been recertified demonstrates a desire to remain at the forefront of his specialty. Simply using the title "family physician" does not guarantee quality medical care. It is imperative that we teach the public to ask, "Will the real family physician please stand up."

Lee A. Fischer, M.D.
West Palm Beach

Reprinted with permission from *Florida Family Physician*, Vol. XXXIV, No. 4, Fall 1984.

CORRESPONDENCE

Lee County Medical Society offers suggestions

Dear Editor: I am writing as the Administrative Secretary of the Lee County Medical Society Bulletin on a number of points of information I would like to share with you.

In the past few years I have noticed no new bulletins, newsletters or magazines have been established by county medical societies which have never set one up. I am sure that their memberships have become larger and need this type of communications. I really feel that sharing information among the county societies is beneficial to all and is a means for the local talents who write to become involved. I would like to encourage the FMA to promote involvement by all county medical societies.

The FMA awards competition would also increase and add more meaning to participation by county medical societies.

Regarding the awards presentation, I am very proud of our Bulletin and feel a lot is contributed to its success by some of my contributions. I do not want to take anything away from our talented editors as they work very hard to make the publications a viable means of communications. I would like to make a suggestion that the county medical society executives involved with their local publications be a part of the awards ceremony and thus give us increased incentive to publish a better tool of communications and share in its success.

In recent years a workshop was set up by *The Journal* to help county medical societies establish a publication of high quality. For anyone just beginning a publication, there does not seem to be anyone to contact and it is a trial-and-error venture with some disappointments that insure failure and no desire to try again. This is also true of established publications as we are placed into the world of the print media, dealing with printers, layout personnel, material, style, finance, etc.

Recently, at one of our meetings, it was pointed out by the FMA leadership that some negative material in one of our local county medical society newsletters would have been better left unprinted. Personally, this material was of interest to our office and membership and was not taken in a negative way. It does point out that we see things on different levels and that county medical societies are without a resource for many items that come across our desks each day dealing with the print media communications. As county executives we usually look to the state organization for direction and when none is there, we must make decisions on the local level.

Above are some of the thoughts I have had regarding the local county medical society publications. I am not sure they fall in the realm of the Editor of *The Journal* but I thought I would start here first. Thank you for taking time to consider the above thoughts.

Ann Wilke
Administrative Secretary
Lee County Medical Society Bulletin

Editor's response

Dear Ms. Wilke: Thank you for your thoughtful letter. I will address your concerns in my capacity as *The Journal* editor, and as a former editor of a county medical society bulletin.

County medical societies without bulletins, newsletters, or magazines certainly need to be goaded into setting these up as one way of enhancing communication among members, increasing awareness of issues, and stimulating participation in the activities of organized medicine. Although there is a core of excellent publications put out by certain county medical societies, as evidenced by the annual FMA Awards Competition, the number of societies in the state without newsletters or bulletins is still impressive. Part of the problem may be the small size of some county medical societies, with very little to report about; part may be financial, since a project like this would entail additional costs to society members. But what about those medical societies where neither one of these factors comes to play?

In my experience as a former bulletin editor for a medium-sized county medical society, Volusia, the most important ingredient in setting up a successful publication, regardless of any perceived obstacle, is in organizing a group of dedicated physicians willing to commit the time and energy into the project, and on a consistent basis. It is like a labor of love. Previous journalistic experience in college helps, but is not necessary. After all, very few of us immersed in physics, biology, and chemistry could find the time to be amateur journalists as well. What is more important is for the physicians to hatch the ideas, and to express them well in correct English. The mechanics of setting up the paper and of proofreading, copy editing, and making the publication presentable can be learned in a few hours at the printing press.

For those who need more help and professional advice, the FMA editorial staff will try to provide assistance in any way it can. Most members of our editorial staff were once editors of their county bulletins, a few still are, and all went through the same rigors of putting out a publication. If there is enough demand, *The Journal* will explore the idea of setting up a workshop on how to develop a medical publication, perhaps in conjunction with the annual FMA meeting. Sandoz also sponsors a similar workshop periodically, with this year's meeting scheduled to be held in Chicago in late October. For others who want to learn things in a hurry, a few books on how to produce a small newspaper or magazine should be helpful.

The Journal of the Florida Medical Association would like nothing better than to see a flowering of editorial talents in the component societies of the FMA. That should make our annual awards competition even better and more interesting. The idea of expanding the annual Editor's dinner to include other people, particularly those who have contributed to their publications, is quite appropriate. As the new editor of the JFMA, I will see to it that this is done. I might add that several other physicians had expressed the same idea at this year's FMA annual meeting.

Finally, your letter touches on the delicate point of what is proper to print in your publication. The nation's most prestigious newspaper, *The New York Times*, carries the blurb of printing "all the news that's fit to print." But who is to judge what is fit to print, and what is unfit? While it is certainly true that it may be better to leave unprinted certain "negative materials," there are occasions where publication of such materials may serve a purpose. Most newspapers and magazines, even the best ones, thrive on printing a lot of what is negative. I am not saying we should do that. In a situation where questions of propriety, ethics, confidence, legality, or delicacy crop up, the editor and his staff should always exercise their best judgment, and such judgment may come about only after painful and agonizing appraisal of the facts at hand, perhaps in consultation with those who have expertise on the subject in question. It is true there is no central clearing-house where an editor confronted by the kind of situation above can turn to; nevertheless, it is still prudent to consult with the county medical society or the FMA or any appropriate body if the publication of certain materials may be inimical to the interests of these organizations. Without belaboring the point, a common-sense approach to potential problems still works best, with no cry for censorship at that.

Your letter, I hope, will stir some dormant souls and stimulate them into the kind of involvement in their county medical societies that other physicians are already engaged in. Communication will always be a vital link in the success of organized medicine. As an editor, I applaud your concern and efforts.

R. G. Lacsamana, M.D.
Editor

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"Sickle Cell Anemia Scam"

Investigations in the St. Louis area have uncovered an innovative scam involving the Schedule III Codeine containing analgesics, especially TYLENOL #3 and #4.

Children who have been diagnosed as having Sickle Cell Anemia were being used by their parents to obtain huge quantities of TYLENOL #3 and #4. Medicaid was paying for these prescriptions and reported this situation to Bureau of Narcotics and Dangerous Drugs.

Further investigation revealed the nature of the scam involving a family with three children, one boy who was confirmed to have Sickle Cell Anemia and two girls who apparently had nothing wrong with them at all. Several physicians were prescribing controlled drugs for the boy but one physician in particular was also prescribing numerous TYLENOL #3 and #4 prescriptions to the two girls.

The boy's primary physician was contacted and reported the pain associated with Sickle Cell Anemia ran in cycles and the boy should be able to go for several days without the use of any controlled drugs until they were needed again.

Discussion with the physician prescribing for the two girls indicated the boy's father made the physician believe both of the girls also had the disease and that was the reason he was prescribing so many controlled drugs for them.

It was later learned that the father was apparently involved in selling the TYLENOL #3 and #4 and that his wife was an addict. Since this situation was uncovered, even though the entire family is "locked in" to one doctor and one pharmacy under the Medicaid program, none of the family members have been seen or heard from. This is another unfortunate case of parents unscrupulously using their children to divert controlled drugs.

Reminder • Physicians should remember that generally patients obtaining large quantities of controlled drugs need more monitoring than the patient who is not receiving large quantities. The physician should be certain in his or her own mind that the patient is using the controlled drugs in the proper and reasonable manner intended and investigate unusual requests for additional quantities or increased drug strength.

CORRECTION

Improving care for indigents

The following sentence in Correspondence of the June 1985 issue, page 456, first paragraph, should have read "However, as medical care has become expensive and providing care for the indigent is such a problem, the time has come for this noble idea."

YOUTH AT RISK

Outward Bound® Directive

A Special Program That Works.

The Hurricane Island Outward Bound Directive Program is a deliberately structured outdoor educational process dealing with motivational and behavioral problems.

By overcoming the challenges of this special Outward Bound course, the students steadily develop their self-image, sense of responsibility and the will to achieve.

Many schools have recognized the significance of the Outward Bound experience by granting high school credit during the school year.

Florida Program — February-December Maine Program — June-September.

Send for free descriptive catalog or call toll-free 1-800-341-1745 for more information.

Inquire now, before it's too late!

Name _____

Street _____

City _____ State _____ Zip _____

☐ Send financial-aid information.

Send to: Hurricane Island Outward Bound School, 823 Thomasville Rd., Tallahassee, FL 32303.

C

He Thought That Drinking Wouldn't Make Any Difference, Even Though He Was on a New Medication. But It Did.

Now he knows that alcohol and some medicines don't mix. In fact, more than half the 100 most prescribed drugs have at least one ingredient that can cause trouble if taken while drinking alcohol. The result of mixing these drugs (alcohol is a drug) may be no more than simple temporary illness, but some combinations can be dangerous, even deadly.

So, don't make a test tube out of your body. Be sure to tell your doctor or druggist about any medications you are taking and be sure to ask about the consequences of mixing a newly prescribed drug with alcohol.

Also, make it a habit to check the label carefully when you get a drug, whether it's a prescription or over-the-counter medication.

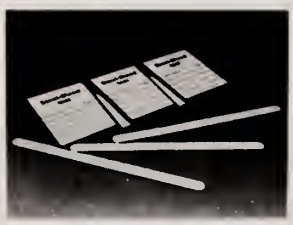
And when you get any prescription, be sure you know—

- **The name** of the drug
- **Its purpose**—what conditions does it treat?
- **How and when** to take the drug—and when to stop taking it
- What **food, drinks and other drugs to avoid** while taking it
- What **side effects** may result—are they serious, short-term, long-term, etc.?

If you have any questions about your prescription, *ask your doctor or pharmacist.*

A message from the Food and Drug Administration. For more material about being an informed patient, write to: FDA, HFE-88, Rockville, Md. 20857.

50,000 people will be saved from colorectal cancer this year. You can save one.



Save yourself! Colorectal cancer is the second leading cause of cancer deaths after lung cancer. More than 90% of colorectal cancers occur equally in men and women past age 50. Early detection provides the best hope of cure. That's why if you're over 50, you should take this simple, easy slide test of your stool every year.

Two days before the Stool Blood Test, you begin an easy-to-follow diet listed in the kit. The kit is chemically treated to detect hidden blood in the stool which usually indicates some problem in the stomach or bowel, not necessarily cancer. Positive tests must be followed by further testing to find out what the problem is.

Other tests for colorectal cancer you should talk to your doctor about: digital rectal exam (after 40), and the procto test (after 50). Tell him of any family history of colitis, polyps, and any change in your bowel habits which could be a cancer warning signal.

The American Cancer Society wants you to know.

AMERICAN CANCER SOCIETY

BOOK REVIEW

Book Review Editor — F. Norman Vickers, M.D.

The social transformation of American medicine

By Paul Starr, Ph.D., 514 pages. Price $24.95. Basic Books.

In this prize-winning book Professor Starr traces the origins of American medicine from colonial times to the present. Full of facts and figures, the book is written in a sociological context. The author teaches at Harvard University and is recognized as an authority on sociology. With his background, Mr. Starr weaves a tale that combines history, sociology and politics into a work that guides the reader through 200 years of American medicine. It is tedious to read in some areas, as the sociological and academic aspects tend to obscure the fascinating story. Most doctors do not know the history of their profession, the struggles it faced and eventually the triumph from a profession without power or respect to one of prestige and authority. For modern day doctors, it is revealing to see that the medical profession was considered one of the lowest professions of early America, a carry-over from the European view. This book is a study of how the medical profession came to power through creating its own authority. This authority was created chiefly to control licensure and educational requirements and to gain control of the hospital environment.

Prior to Medicare in 1965, the medical profession had already fought many battles with trade unions and the federal government over various approaches to socialized medicine. The Socialist Party in 1904 was the first political party to advocate health insurance. This was during the Progressive Era, a period in American history when many popular reforms were enacted into law such as the initiative, direct election of United States Senators, and the recall and referendum. Out of the agitation for social change came the American Association for Labor Legislation (AALL), which was formed by a group of persons who called themselves Social Progressives. The AALL pushed for health insurance, which would include physician's services along with nursing, death benefits and sick pay. Surprising to the leadership of the AALL, many prominent medical leaders, including the editor of the *Journal of the American Medical Association*, worked with the AALL to come up with a plan. However, opposition from the rank and file of American physicians was formidable and its efforts came to an end because of this and the entry of America into World War I in 1917. Germany had a form of social health insurance and anything associated with Germany in 1917 quickly lost favor.

The sentiment for compulsive health insurance reappeared in the 1930's amid The New Deal, an era of government intervention in response to the depression that was sweeping the United States. President Franklin Delano Roosevelt pushed for health insurance in conjunction with the original Social Security Act. The time appeared right. Many doctors were selling peaches on street corners, knocking on doors to drum up business and affected as adversely by the depression as the rest of the population. The California Medical Association endorsed compulsory health insurance and the Michigan Medical Association supported it for a period of time and had a running battle with the American Medical Association. During the 1930's the AMA and the reformers continued to do battle. By the end of the 1940's most of the doctors were against the idea of compulsory health insurance and apparently so were the people. In 1945 a poll was taken to find out public sentiment and the polls indicated that while a ma-

jority would approve national health insurance, only about one third of the population preferred it to a private system. Because of the opposition of national and state medical leaders, Roosevelt decided not to risk confronting organized medicine. There were more attempts during the 1940's and 50's, which the author deals with in detail. Starr traces the advent of Medicare in 1965 to several factors, such as the expanding technology, rising cost of medical care with this technology, use of antibiotics, x-ray, etc. and increasing usage of medical services in a more liberal society. Medicare proved to be a boon to doctors who were paid for seeing patients they had previously treated gratis.

The last several chapters of this book are the most interesting, and also depressing, to members of the medical profession. It was in the 1970's that a crisis was born when the cost of medical care approached 10 percent of the gross national product and the people became disenchanted with the current system. The medical profession resisted any more inroads into its authority and autonomy. The foe was usually perceived to be the federal government. Professor Starr points out the biggest foe was not, and is not, the federal government. It is the rise of corporations and corporate medicine. In a way, medicine has been hoisted on it own petard. For decades we have decried the intervention of government control and asked for private enterprise or the market place to determine the price of medicine. Now the corporations are employing capitalistic principles, enterprise and marketing to the medical needs of this country. Mr. Starr foresees the last decades of the twentieth century as a time of disintegrating autonomy, reduced income for physicians and a change from private practice to the "corporate doctor." The supply of physicians is helping the corporations to move rapidly into a position of control. From 377,000 physicians in the United States in 1975, the number is expected to rise to 600,000 by 1990. For every 100,000 people, there were 140 doctors in 1960, and in 1990 these 100,000 people will have 240 physicians. This will make America one of the most heavily physician-populated countries in the world. Because of this surplus, many newly graduated doctors will find corporate medicine appealing. Doctors in private practice have helped pile dirt on the grave with unnecessary hospital admissions, testing, etc. The corporations have demonstrated they can be efficient and cut costs. Whether or not this will compromise patient care has yet to be proved.

The great illusion of doctors and hospitals throughout the last two decades was that our problems were caused by a liberal government. Starr feels that they were caused by the demands of physicians put upon private insurance and public programs. This has led to measures such as DRGs and the rise of corporate medicine. He does not lay blame in a derogatory manner, but instead feels that it is a combination of inefficiency, patients' demands, and the protection of medical autonomy to the point that no adjustments in the practice were thought necessary or desirable, even in the face of contradictory evidence.

Corporations are moving rapidly to gain as large a share of the medical market as possible. By 1981 nearly 75 percent of all beds in for-profit hospitals were controlled by the three companies of Humana, Hospital Corporation of America and The American Medical International. As the corporations become more powerful, they will try to modify or control the behavior of physicians. This will represent a change from "professional socialization," the process whereby medical students learn the values and attitudes of graduated and established physicians to that of "corporate socialization" as the young doctors learn to do things and act as the company expects.

Starr ends with the sobering thought that this turn of events is a combination of professional and institutional self-interest, failure of the medical profession to provide effective plans for change and to recognize the forces that were in effect the last 20 years. It is a very enlightening and depressing book for in it we see the missed opportunities, wrong decisions, and recalcitrance that have made the medical profession vulnerable to this end. However, there is a bright note. Professor Starr points out that a trend is not necessarily fact and this image of the future of medicine can depend on choices that Americans, which include the medical profession, still have to make.

H. Frank Farmer, Ph.D., M.D.
New Smyrna Beach

- Dr. Farmer is in private prctice of internal medicine in New Smyrna Beach and is newly appointed Historical Editor of *The Journal.*

in medicine, ineffective bookkeeping can try one's patients.

Research proves it. Late or inaccurate medical billing makes for poor receivables. Patients are more prone to pay in full when statements are on time and complete. (Cleanliness of design helps, too.)

That's where
Southeastern Medical Data Systems
comes in.

Our computer service is state-of-the-art, providing maximum efficiency in accounts receivable, Medicare and insurance processing and follow-up. Plus, we provide all our clients with **customized** monthly reports. The advantages are many.

Valuable time is saved, freeing up the office staff to do the job for which they were trained. Collectibles increase significantly. Automated record keeping in some cases even helps to reduce tax outlays.

Our skilled staff can tailor a system to suit any need. We're small enough to provide the personal touch — and very big on service.

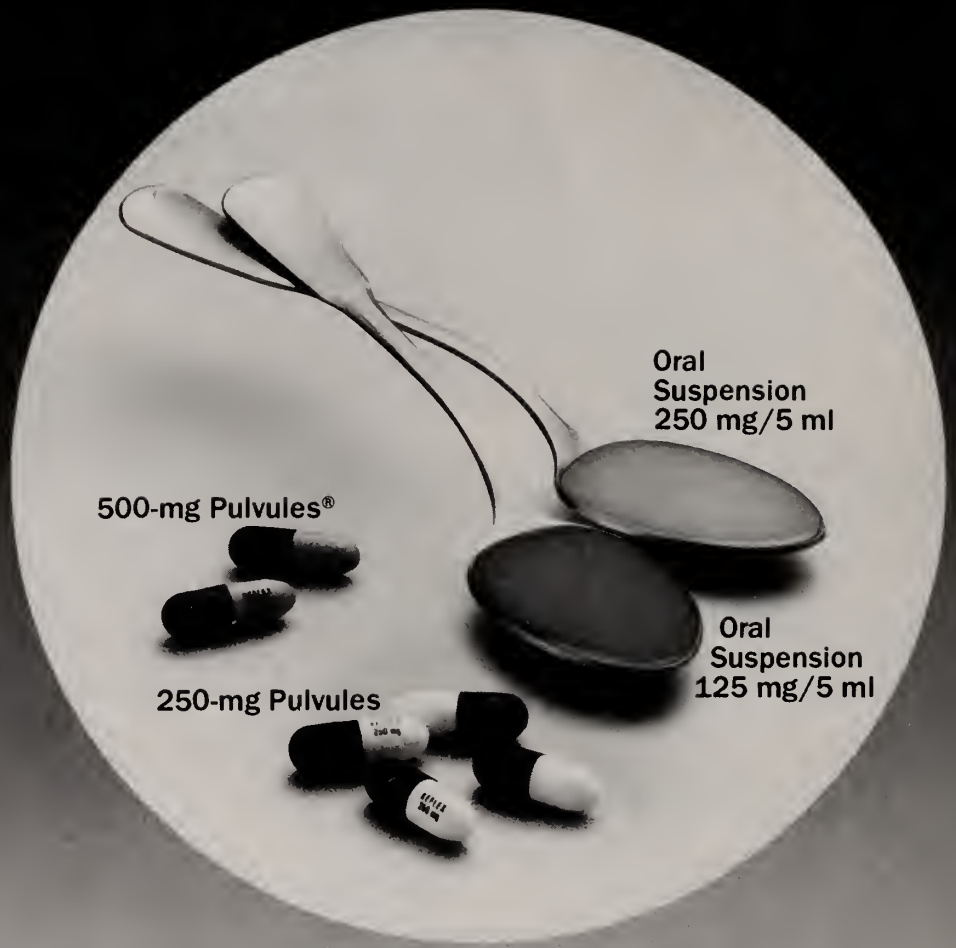
Write or call us for additional information and we'll get back to you immediately.

After all, we wouldn't want to try your patience.

southeastern
medical data
systems

22 west lake beauty drive, suite 310
p.o. box 8308
orlando, florida 32806
(305) 841-9792

Easy To Take



Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA

420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

Medical malpractice — a study in evolutionary politics

At 11:00 p.m., Thursday, May 30th, after more hours, energy and efforts than the FMA staff and leadership could tally, the Malpractice Reform Act of 1985 made its final journey through the Florida Senate. For medicine in Florida, it was the best session in almost ten years. The tide and sentiment of the Florida legislature had shifted. What had been met with skepticism, indifference and even derision in the past had now attained an almost *cause celebre'* status. This legislature had chosen to address an issue the past two previous sessions had refused. What had precipitated this change? What had made the 1985 legislature so different from many of its predecessors?

From the perspective of one who has actively followed this issue through the demise of mediation panels, the "recovery of costs", the yearly attempts by medicine to obtain legislative relief, the court's negative decision on Amendment 9, and finally as a relieved and weary observer of the closing hours of the 1985 session, I have concluded how this whole process had to evolve.

Most would remember from their high school civics course the classic definition of a revolution — that sudden, radical or complete change. While the malpractice crisis has warranted, in the minds of many, sudden, radical or complete change, revolution has never been a realistic much less operative possibility. No matter how frustrating, how miserable or unfair, it is unlikely that physicians in Florida would rise in protest, and foment a medical malpractice "revolution." Instead, what has occurred and continues to do so, is the decidely more civil, certainly more politically expedient alternative to revolution — that is, evolution. As defined, evolution is that process of "gradual and relatively peaceful social, political and economic change." It is this evolution over the last ten years that has delivered Representative Art Simon's Malpractice Reform Act of 1985.

Several sessions had to pass before many legislators would even admit there was a malpractice "problem". When confronted with the issue, a common tack was to blame the high insurance premiums and the necessity for defensive medicine on the "bad doctor". Friends in the legislature were blunt. Medicine had an "image" problem. From "bad doctors" to accusations of being interested only in "pocketbook issues", physicians were under attack.

To medicine's credit it learned from its defeats; there was ample opportunity. It listened to friends and studied its detractors. It began to address the problem by becoming more active in the political process. As political awareness increased, issues that affected the quality of life in Florida were addressed and actively supported.

Amendment 9 brought the malpractice issue clearly to the people. For the first time medicine had a statewide forum and an indisputable recognition that a malpractice crisis existed in Florida. Amendment 9 may have failed in the Supreme Court, but not before it left its indelible imprint on the evolutionary process.

Medicine found the 1985 legislative session to be the most receptive in ten years. It enjoyed the support of both House and Senate leadership, which is essential to the passage of any legislation. There was a determination to legislatively address the cry for malpractice reform. While Rep. Art Simon's Malpractice Reform Act is a victory for medicine, it is not a solution to the problem. Rather it must be observed as one more step in the evolutionary process — a step that will move medicine that much closer to its goal, a fair resolution to a crisis that adversely affects the delivery of health care to every citizen in Florida.

Carolyn C. Spore
DeLand
State Legislative Chairman
Florida Medical Association Auxiliary

KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used.

Mrs. Michael John Murray (Candy)
Lee County

Rx for fine dining:

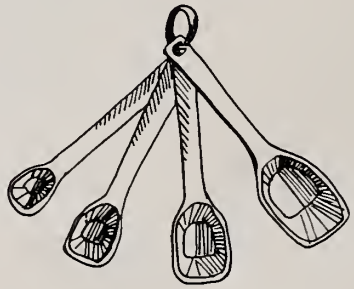
—A collection of over 700 gastronomical delights.

—Eight sections from appetizers to desserts - including many outstanding game, seafood and sauce recipes.

—Full color cover with original pen and ink illustrations dividing the sections.

—Spiral bound and indexed with menus, helpful hints and potpourri.

—Compiled by the Florida Medical Association Auxiliary for the benefit of health related projects.



Rx FOR FINE DINING
P.O. Box 2411
Jacksonville, FL 32203

Please send me _____ copies of Rx For Fine Dining at $10.00 per copy plus $1.30 for postage and handling. Florida residents add $.50 sales tax.

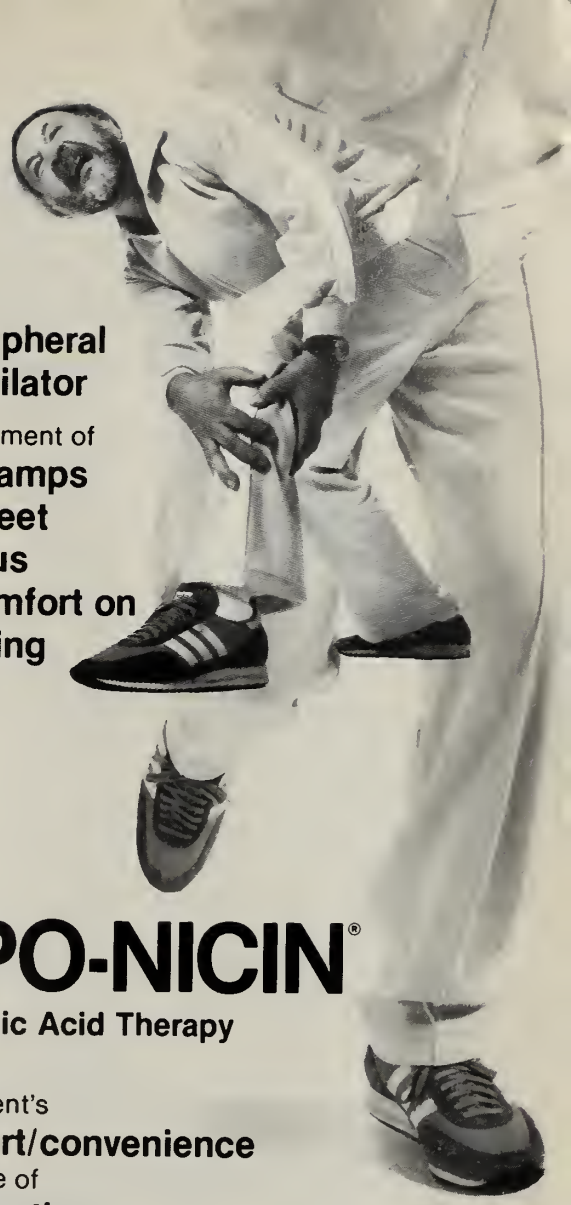
Make checks payable to — COOKBOOK PROJECT, FMA-A
P.O. BOX 2411
JACKSONVILLE, FL 32203

Name _____

Address _____

City, State, Zip _____

COOKBOOKS MAKE GREAT GIFTS!



Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

AUGUST

Controverises in Carcinoma of the Breast, August 7-10, Hyatt Regency Grand Cypress, Orlando. For more information, contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, 813-974-2538.

Tips, Tricks, Traps and Techniques, August 16-18, Amelia Island Plantation, Amelia Island. For information contact: Beverly Tyson, 655 W. 8th Street, Jacksonville 32209, 904-739-2338.

Arrhythmias: Interpretation, Diagnosis and Management, August 16-18, Orlando Hyatt, Orlando. For information call: Stephen Mattingly, 1-800-421-2323.

SEPTEMBER

Advanced Cardiac LIfe Support, Sept. 13-15, Marion Community Hospital, Ocala. For more information: Marion Community Hospital, Inservice Education Dept., 1431 S.W. First Ave., Ocala, 32671.

Current Concepts in the Diagnosis of Adult Heart Disease IV, Sept. 13-14, New World Inn, Pensacola. For more info call D. Bruce McGraw, M.D., P.O. Box 151, Pensacola, 32591-0151, (904) 478-4121.

International Symposium on Gynecologic Oncology, Surgery and Urology, Sept. 23-27, Germany. For more info: William A. Little, M.D., Deparment of Obstetrics and Gynecology, P.O. Box 016960, Miami 33101, 305-549-6944.

Ninth Annual Medical Aspects of Aging, Septembe 27-28, University of Florida Gainesville. For information call: Grace Wagner, JHMH(J-233, Gainesville 32610, (904 392-3143.

OCTOBER

Eleventh Annual PanAmerican Seminar, Oct. 14-18, Mount Sinai Medical Center, Miami Beach. For more info: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Advanced Neuroradiology Seminar, October 16-19, Hilton Hotel, Lake Buena Vista. For information: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Thirty-ninth Regional Family Practice Weekend, October 25-27, Marriott Biscayne Bay Hotel, Miami. For information: Charles A. Dunn, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Ninth Annual Medical Aspects of Aging, October 27-28, University Centre Hospital, Gainesville. For information: James A. Jernigan, M.D., JHMHC-J-233, Gainesville, 32610, 904-392-4321.

Fall 1985 Family Practice Review, October 27-November 2, Orlando. For information: Grace Wagner, JHMHC, J-233, Gainesville 32610 (904) 392-3143.

Fall 1985 Family Practice Review, Oct. 28-Nov. 1, Palace Hotel, Lake Buena Vista. For information: Lamar Crevasse, M.D., JHMHC J-233, Gainesville, 32610, (904) 392-3143.

Clnical Applications for Pulsed, Continuous Color Flow Doppler Echocardiography, Oct.31-Nov. 1, Mount Sinai Medical Center, Miami Beach. For information: Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140, (305) 674-2311.

Nutrition In Pediatric Practice, October 30-November 1, Don Cesar Resort, St. Petersburg. For information: Herbert Pomerance, M.D., JHMHC, J-15, Tampa 33612, 813-974-4214.

NOVEMBER

Twenty-sixth Workshop in Electrocardiography, Nov. 1-4, Sheraton Sand Key Hotel, Clearwater. For information: Henry Marriott, M.D., 601 12th Street N., St. Petersburg 33705, (813) 894-0790.

Spinal Deformities, November 3-6, Sheraton Bal Harbour, Bal Harbour. For information: Barry Silverman, 2050 N.E. 163rd Street, N. Miami Beach 33162, (305) 944-4746.

Ninth Annual Seminar: Evolution in the Total Care of the Pediatric Hematology/Oncology Patient, November 21-23, Hyatt Orlando, Orlando. For information: Cindi Butson, P.O. Box 13372, University Station, Gainesville 32604, 904-375-6848.

DECEMBER

Ear, Nose, & Throat Diseases in Children, December 7-11, The Breakers, Palm Beach. For information: 125 DeSoto Street, Piladelphia, PA 15213, 412-647-5466.

Techniques of Therapeutic Endoscopy, December 4-6, Contemporary Resort Hotel, Lake Buena Vista. For info: H. Worth Boyce Jr., M.D., USF College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612 (813) 974-2034.

Clinical Allergy and Immunology for the Practicing Physician, Dec. 5-7, Palace Hotel, Lake Buena Vista. For info: Richard F. Lockey, M.D., VA Hospital, 13000 N. 30th St., Tampa, 33612, (813) 972-2000, ext.596.

Theoretical and Clinical Considerations Affecting the Selection of Neuroleptic Agents, December 6-7, Boca Raton Hotel, Boca Raton. For information: Millie Toberts, P.O. Box 016960, Miami 33101, 305-549-6327.

CLASSIFIED ADVERTISING ORDER BLANK

(PLEASE PRINT OR TYPE)

Name:_____

Address: _____

_____ Phone: _____

AD COPY

_____

_____

_____

_____

_____

_____

INSERTION DATA

Run ad for the month(s) of: _____

☐ Check here for box number ($1.00 additional)

Place Ad Under: (mark one)

☐ Physicians Wanted	☐ Real Estate	☐ Equipment
☐ Situations Wanted	☐ Art	☐ Services
☐ Practices Available		

☐ Enclosed is my check in the amount of $_____ (payable to the FMA)

☐ Please bill

Signed _____

CLOSING DATE: First of the preceding month.

Detach and return to *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, Florida 32203.

Classified Ads

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Physicians Wanted

PRIMARY CARE FACILITY in West Palm Beach seeking part time physicians for hourly work, and full time positions for future facilities. Send CV to: Administrator, P.O. Box 25986, Tamarac, FL 33320.

FAMILY PRACTICE opportunity: Established, successful family practice opportunities for Family Practitioners or Internists in the Miami, Ft. Lauderdale, Palm Beach and Tampa areas. Board eligible or certified preferred. Excellent professional and economic growth potential. State license required. Respond with CV to: Fern Blum, EMSA, 8200 West Sunrise Blvd., Building C, Plantation, FL 33322, or call (305) 472-6922.

EMERGENCY PHYSICIANS: Professionally oriented, emergency physician group has immediate full time opportunities for well-qualified emergency physicians in hospitals located on coastal Florida. Excellent compensation package. Respond with CV to: Karen Block, EMSA, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 or call (305) 472-6922.

FAMILY PRACTICE OR EMERGENCY MEDICINE physician opening in a private freestanding emergency center. Excellent location. Highly attractive practice setting. Send CV to: Michael J. Webb, M.D., Harrell Medical Center, 1805 SE Lake Weir Avenue, Ocala, FL 32627 or call (904) 629-0642.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

ANESTHESIOLOGIST with a minimum of eighteen months experience in Pediatric Anesthesia and six months of full-time experience in Cardiothoracic Anesthesia. Must be certified by the American Board of Anesthesiology or equivalent. Clinical and teaching ability. Hours 8-4; annual salary: $85,000; report to Job Service of Florida, 1350 N.W. 12th Ave., room 280, Miami. Refer to job order No.: 4540026.

GENERAL INTERNISTS, PEDIATRICIANS,AND FAMILY PRACTITIONERS: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

PRIMARY CARE CENTERS in Florida: Recruiting aggressive emergency medicine and family practice trained physicians to staff centers on a full-time basis. Positions available in central and south Florida coastal communities. Excellent opportunity - guaranteed salary, fee for service incentives, profit sharing with public corporation, malpractice insurance paid. Send CV to F.M.C., 250 N. Babcock St., Suite 202, Melbourne, Florida 32935.

RESIDENCY DIRECTOR: University Hospital of Jacksonville, a large non-profit teaching hospital, is seeking a physician with residency and administrative experience to lead new Family Practice Residency. Competitive salary and excellent fringe benefits. Send C.V. to John A. Grisnik, Jr., M.D., Department of Community Health and Family Medicine, University Hospital of Jacksonville, 655 West 8th Street, Jacksonville, Florida 32209.

COME TO PARADISE: Rewarding primary care practice in Key West, Florida. Join the Island Clinic Group. Phone 305-294-4657. Ask for John Buckner.

EXPERIENCED, BOARD CERTIFIED SPECIALISTS in orthopedics, neurosurgery/neurology, and EMG wanted for part time association with office based group performing medico-legal evaluations in Dade and Broward Counties. We offer excellent renumeration with no nights or weekends on call, and minimal malpractice exposure. Call (305) 557-0900 or send C.V. to Medical Director, Southern Diagnostic Associates, Inc., 1575 West 49th Street, Suite 132, Hialeah, Florida 33012.

PRIMARY CARE PHYSICIANS to associate with Free Standing Walk-In Center, some ER experience helpful. Please send CV or contact Jensen Beach Emergi-Centre, 1801 NE Commercial Street, Jensen Beach, Fl 33457, (305) 334-1700.

ANTERIOR SEGMENT FELLOWSHIP in busy private practice associated with medical college. Intraocular lens implantation, including posterior chamber and anterior chamber lenses. Extracapsular and Phacoemulsification techniques. Argon and Yag Laser. Excellent benefits plus fringes. Send CV and career objectives to: C-1242, P.O. Box 2411, Jacksonville, FL 32203.

FORT LAUDERDALE, MIAMI, PALM BEACH. Physicians for family practice centers. Immediate openings. Benefits, profit sharing & tenure available. Call Dr. Verblow (305) 474-4403 or write FHCC, 7730 Peters Road, Plantation, Florida 33317

FAMILY PHYSICIAN TO JOIN busy internist in Florida Keys. Office has laboratory, EKG and X-ray capabilities. Will provide very flexible association to the right individual. Send CV to: Robert Carraway, M.D., P.O. Box 2008, Key West, FL 33040 (305) 294-0511.

PEDIATRICS: Established Pediatrician needs associate. Board E/Q and U.S. Trained. Partnership or share pediatric call and expenses in group of 3 (2 internists and pediatrician) on central Florida east coast. C-1266, P.O. Box 2411, Jacksonville, FL 32203.

WANTED — INTERNIST with interest in cardiology or rheumatology. Opportunity available in beautiful lakes and hills of Central Florida, 25 miles north of Orlando. In established fully equipped clinic, lease with later option to buy. Close to 150 bed hospital which will guarantee adequate income first year. C-1270, P.O. Box 2411, Jacksonville, FL 32203.

ORTHOPAEDIC SURGEON — wanted to join an established surgeon, southeast Florida, Boynton Beach area. Send CV: C-1279, P.O. Box 2411, Jacksonville, Fl. 32203.

WANTED: IM, FP, OR GP to share furnished and fully equipped office building with General Surgeon, Orthopaedic Surgeon, Family Practitioner and Gynecologist. Location established 35 years. Adjacent to major hospital diagnostic center in North Miami, Florida. Facilities include X-Ray, Minor Surgery, EKG, computerized billing and insurance. Send CV to office manager, 12996 W. Dixie Hwy., N. Miami, Fl 33161, (305) 891-6589.

POSSIBLE OPENING FOR UROLOGIST. Established practice in Naples, Fl. All you need in one package. Call (813) 262-3996 or (813) 262-1521 for further information.

INTERNAL MEDICINE: Central Florida east coast. Shared expenses in group of four with well equipped lab, x-ray. Board eligible/qualified, and U.S. trained. Rent $300.00 a month. Contact T.C. Kenaston Jr., M.D., Box 550, Cocoa, FL 32923-0550.

PHYSICIANS: Progressive, physician-owned medical group has positions available in the SE Florida area. Experienced, Board-prepared or Board certified physicians are preferred with interests in primary care, internal medicine, emergency and critical care medicine. Competitive salary, fringe benefits, paid malpractice insurance. Call (305) 325-1381 or send CV to Emergency Medical Group, P.A., 1400 NW 12 Ave., Miami, FL 33136.

FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

ST. PETERSBURG: Opportunity for experienced emerging physician in low-volume E.D. on Florida's Gulf Coast. ACLS essential, ATLS encouraged. Send C.V. to S. MacLeod, M.D., 8601 Merrimoor Blvd., E., Largo, FL 33543, or call 813/397-7234.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4240.

FAMILY PHYSICIAN, Board certified, to join a well established solo practice in Central Florida. Initial salary with early opportunity for partnership. For further information, please call (813) 859-2748.

GROUP OPENING for residency — trained F.P. to join growing group of young boarded, residency-trained F.P.s. Contact: Roman M. Hendrickson, M.D., P.A., 621 South Nova Road, Ormond Beach, Fl. 32074, (904) 672-5084.

WORKING MEDICAL DIRECTOR wanted for outpatient walk-in center. Private practice opportunity on Florida Gulf Coast. Available immediately. Financial renumeration based on % of gross receipts. Respond with resume including phone number to Medical Clinic, P.O. Box 25312, Tampa, Fl 33622.

FAMILY PRACTICE/GERIATRICS, active. North Tampa/USF area. Completely equipped office including new X-ray, HME*, Spirometry, and Motorola Cellular portable telephone. Serious inquiries only.

EMERGENCY MEDICINE/URGENT CARE CENTERS — We have several attractive opportunities available in hospital based emergency rooms, and free standing urgent care centers in Florida, Georgia and Alabama. We seek U.S.-trained, board certified/board eligible EM/IM/FP experienced physicians. Malpractice and competitive salary offered. Low to moderate volume and flexible scheduling. Send C.V. to J.M. Garner, M.D., Dept. J, 890 S.R. 434 North, Altamonte Springs, Fl. 32714 or call Sandy Teal, 305-788-0786.

FAMILY PRACTICE Physician with good experience in emergency medicine needed along S.E. Florida coast. Send resume to: C.P. Viado, M.D., 805 Virginia Avenue, Suite 11, Ft. Pierce, FL 33482.

PSYCHIATRIST — full-time position open for board certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient only. Florida license needed. Write or call: A. Mullin, M.D., Mental Health Clinic of Jacksonville, Inc., 2627 Riverside Avenue, Jacksonville, Fl. 32204, Phone (904) 384-2364.

OPHTHALMOLOGIST, BC/BE, to join very busy solo ophthalmologist. North Central Florida. Good hunting, fishing, boating, near ocean. Industrial, tourist, retirement area. Could gradually assume practice as Senior Partner slows down. Contact: P.O. Box 17038, Jacksonville, Fl. 32216.

Situations Wanted

BOARD CERTIFIED PEDIATRICIAN, Florida licensed, seeks group practice in Florida. C-1227, P.O. Box 2411, Jacksonville, Fl 32203.

ANESTHESIOLOGIST: 36, Florida licensed, in process of ABA Certification, Fellowship in Pain Management, group practice last two years, extensive experience in Regional Anesthesia, desires to settle in Florida, consider any opportunity, Available anytime. Reply: Dharia, M.D., 67-02 230th St., Bayside, N.Y., 11364, 718-225-5804.

LOCUM-TENENS work wanted in primary care facility, or office practice. Coverage provided by licensed and insured physicians. Radiologists also available. Call 1-800-545-4141, Ext. 257.

LOCUM-TENENS: Radiologist, Board Certified, 53, academic and administrative experience, does most modalities, will also consider permanent association. Please write Box C-1265, P.O. Box 2411, Jacksonville, Fl. 32203.

BOARD CERTIFIED INTERNIST, Florida licensed, looking to join solo or group primary care practice on east coast. Available immediately. Reply: Charles Gelfman, 123-33 83rd Ave., Apt. 1605, Kew Gardens, N.Y. 11415 or call evenings (718) 544-9662.

Practices Available

INTERNAL-MED, FAMILY Practice est. 30 years for sale. Eager to retire. No reasonable offer refused. No cash needed for physician just completing residency. Five local hospitals require Board Eligible. Write Medical Center, P.O. Box 7603, West Palm Beach, FL 33405.

INTERNAL MEDICINE practice for sale in Central Florida, about 80 south of Disney World. Board Certified Internist wishes to retire after 26 years of active practice. Prefer Internist with sub-specialty of Cardiology. Reply to Box C-1269, P.O. Box 2411, Jacksonville, FL 32203.

OTOLARYNGOLOGY practice, established 27 years. Patients records, equipment and office available. Price negotiable. Otolaryngologist, Suite E, 500 Memorial Circle, Ormond Beach, FL 32074.

UROLOGIC PRACTICE FOR SALE. N. Central Florida. Have just retired. Same location over thirty years. Office equipment for sale. Lovely two-man urologic building adjacent to local hospital also for sale. Florida license is essential. Reply Box C-1273, P.O. Box 2411, Jacksonville, FL 32203.

PEDIATRICS — North Fl., well established, fully equipped, centrally located, hospitals nearby, good clientele, quality practice, charts, equipment, goodwill transferable; office building for purchase or rent, terms flexible, BE/BC, contact C-1275, P.O. Box 2411, Jacksonville, FL 32203.

OPHTHALMOLOGY PRACTICE for sale — Location: Northeast Florida. Gross $500,000±, potential move, room for two. Building 4200 sq. ft. over 20 exam, treatment work rooms, busy optical shop. One-half acre corner lot. Hospital one-half mile. Contact C-1276, P.O. Box 2411, Jacksonville, Fl. 32203.

CENTRAL FLORIDA. 30-year busy B.C. family practice. Two-man building/land. Need associate, B.C., share expenses, to introduce into practice. Ultimately lease or purchase. C-1280, P.O. Box 2411, Jacksonville, Fl. 32203.

UROLOGICAL PRACTICE: office and equipment in S.W. Florida. (813) 262-3996.

Real Estate

DECORATED OFFICE SPACE AVAILABLE in the beautiful Lighthouse Point Professional Building at 2211 NE 36 Street, Lighthouse Point, Florida. For details please call (305) 942-1444.

GREAT OPPORTUNITY: Active Delray Beach Medical Building — 1800 sq. ft. available. $13.00 sq. ft. will divide. Lg. Internal Medical group ground floor. 305-272-7428. Ask for Jan.

GAINESVILLE, Bellamy Forge, 3 BR, 2½ B, attached garage, condo with all amenities, mint condition, $56,500.00. (813)254-3412.

MUST SELL: Beautiful condominium Palm Beach area. Two baths, two bedrooms. Pool private sun deck. Contact P.O. Box 2914, Winter Park, 32790.

SOUTH MIAMI MEDICAL ARTS BUILDING: All specialties. Adjacent to two hospitals. 1500 - 1800 sq.ft. Fully partitioned and carpeted. Reasonable rent. (305) 661-5147.

Services

PHYSICIANS SIGNATURE LOAN PROGRAM to $50,000. Up to seven years to repay with no prepayment penalties. Competitive fixed rate, with no points, fees or charges of any kind. Courteous, prompt service. Physicians Service Association, Atlanta, GA. Toll free (800) 241-6905. Serving the medical community for over 10 years.

LONG TERM FINANCING available for office buildings, office condos, diagnostic centers, equipment. No points. Western Financial Capital, 1380 Miami Gardens NE, Suite 225, North Miami, FL 33179, (305) 949-5900.

WE BUY, SELL, LEASE SERVICE new and reconditioned medical instrumentation: EKG, Lab, Holter, scanners, 2 D. Echos, stress-test, etc. Contact: Ed Bentolila, P.O. Box 8767, Coral Springs, FL 33065, 305-972-4600.

GREAT SOUTHERN QUAIL hunting at Georgia's fastest-growing quail preserves. Relaxing, enjoyable pastime for busy physicians. Call or write: Fred Purvis R.Ph., Mesa Hunt Preserve, Rt. 2, Box 386 A, Adel, Georgia. Tel. (912) 896-2400 or (912) 896-2637 or beeper (912) 333-6001, may leave message.

HOLTER SCANNING AND INTERPRETATION nationwide. For offices or hospitals at very special rates. Includes cardiology interpretation, immediate phone reporting, etc. Special rates for hospitals, HMO's. Will provide recorder and arrange for your office to learn patient connection, quality, etc. For information call Pittsburgh Cardiovascular, (412) 372-2035. 2550 Mosside Boulevard, Monroeville, PA 15146.

Equipment

COMPLETE RADIOGRAPHIC Fluoroscopic X-ray room with 10 y.o. Picker 90/15 table. Morror optics and precise optics T.V. system included. The image intensifer, fluoroscopic X-ray tube and automatic brightness system are only one year old. Call Kissimmee Memorial Hospital (305) 846-4343, Ext. 387 for Dr. Sessions or Dr. Mayo.

Meetings

THE THIRD ANNUAL ADVANCED NEURORADIOLOGY SEMINAR sponsored by the Departments of Radiology at the University of South Florida College of Medicine and Tampa General Hospital will be held in the Walt Disney World Village Hilton, October 16-19, 1985. The course will stress the more recent advances in NMR, CAT Scanning and Interventional Neuroradiology. Guest faculty will include Drs. Bradley, Daniels, Fitz, Hachinski, Michelsen, Modic and Vinuela. The fee is $340 for 16 Category I Credit hours. Call Charleen Kirissman 813/974-2538 for more information.

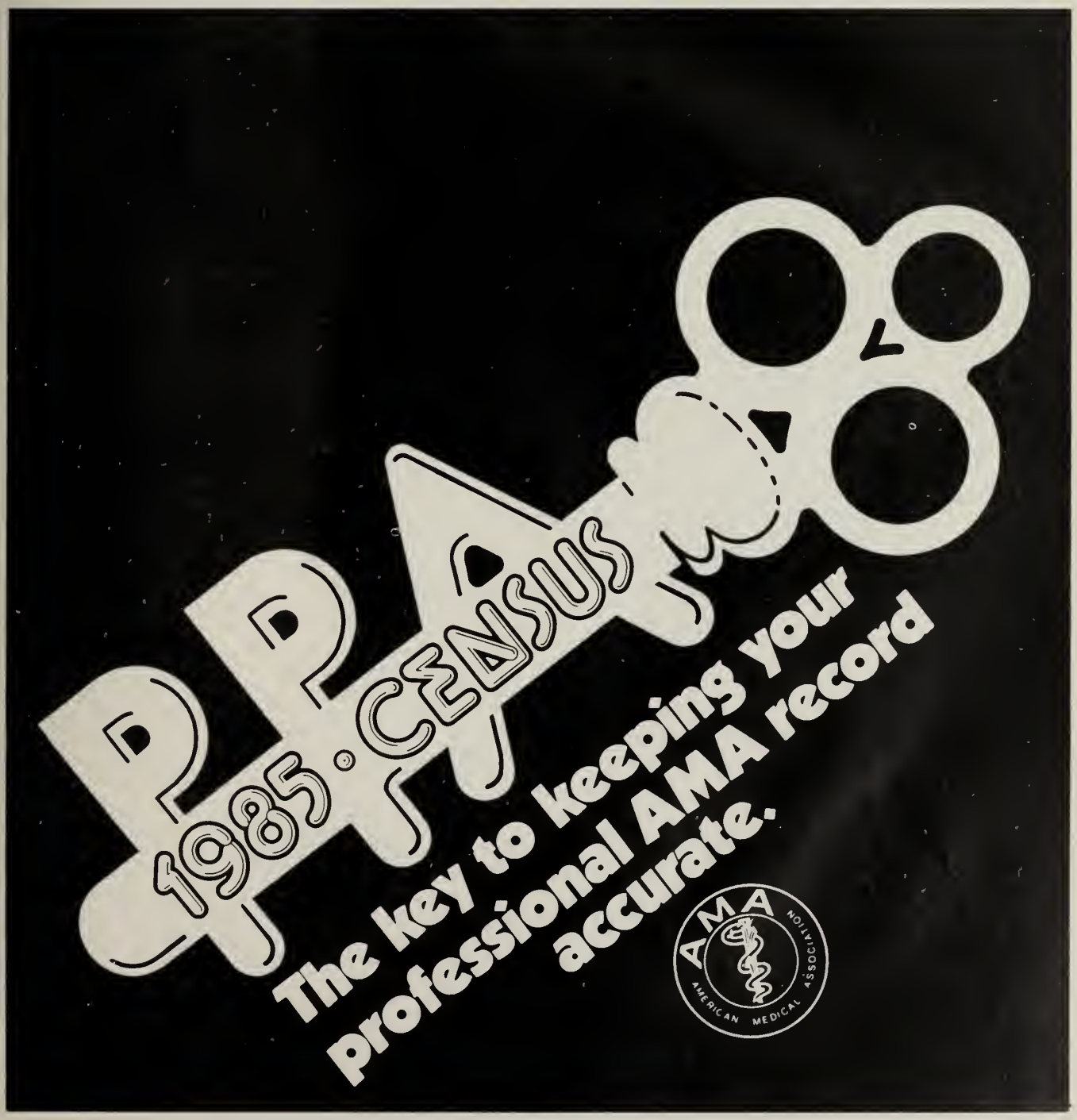
Physicians!
Plan to Participate When Your Census Form Arrives

Completing and mailing in your Physicians' Professional Activities Census form will ensure:

- That your professional record is updated on the AMA Physician Masterfile;
- That you are correctly classified by specialty and activity in the AMERICAN MEDICAL DIRECTORY;
- That you continue to receive educational and scientific materials relevant to your professional interests.

Call or write if you have not received a census form by April 1985:

Division of Survey & Data Resources
American Medical Association
535 North Dearborn Street
Chicago, IL 60610
(312) 645-5136



ADVERTISERS

Florida Medical Association Officers and Council Chairmen

Officers

Luis M. Perez, M.D., Sanford, President
James B. Perry, M.D., Ft. Lauderdale, President-Elect
James G. White, M.D., Ormond Beach, Vice President
Henry M. Yonge, M.D., Pensacola, Secretary
Yank D. Coble Jr., M.D., Jacksonville, Treasurer
Guy T. Selander, M.D., Jacksonville, Speaker of the House
Arthur L. Eberly Jr., M.D., Lighthouse Point, Vice Speaker
Donald C. Jones, Jacksonville, Executive Director and C.E.O.

Chairmen

Joseph H. Davis, M.D., Miami, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Richard S. Hodes, M.D., Tampa, Co-Chairman, Medical Economics
Charles P. Hayes Jr., M.D., Jacksonville, Co-Chairman, Medical Economics
Joseph T. Ostroski, M.D., Miami, Medical Services
Pierre J. Bouis Jr., M.D., Tampa, Scientific Activities
William T. Hawkins, M.D. Gainesville, Specialty Medicine
T.M. Daniel, M.D., Clearwater, Hospital Medical Staffs

EXCERPTS FROM A SYMPOSIUM
"THE TREATMENT OF SLEEP DISORDERS"[8]

"...highly effective for both sleep induction and sleep maintenance"

Sleep Laboratory Investigator
Pennsylvania

"...onset of action is rapid...provides sleep with no rebound effect to agitate the patient the following day"

Psychiatrist
California

"...appears to have the best safety record of any of the benzodiazepines"

Psychiatrist
California

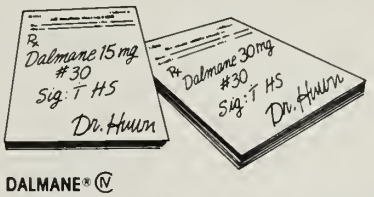
After 15 years, the experts still concur about the continuing value of Dalmane (flurazepam HCl/ Roche). It provides sleep that satisfies patients... and the wide margin of safety that satisfies you.

The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche
sleep that satisfies

15-mg/30-mg capsules

References: 1. Koles J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Koles A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Koles A, *et al. Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Koles A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978. **7.** Koles A, Koles JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **8.** Tennont FS, *et al:* Symposium on the Treotment of Sleep Disorders, Teleconference, Oct 16, 1984. **9.** Greenblatt DJ, Allen MD, Shoder RI: *Clin Pharmacol Ther 21*:355-361, Mor 1977.



DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

#1 IN EXPERIENCE

Worldwide, it's a known quantity... known for sleep that satisfies.

You know it helps patients fall asleep quickly and stay asleep till morning.[1-8] You know its exceptionally wide margin of safety.[7-9] You know it better than any other hypnotic. The *only* benzodiazepine hypnotic with more than 15 years of continuing satisfactory performance. As always, caution patients about driving or drinking alcohol.

Please see references and summary of product information on reverse side.

DALMANE® (IV)
flurazepam HCl/Roche
sleep that satisfies

ROCHE®